REPORT TO THE GOVERNOR:
THE EFFECTIVENESS OF LOCKS AT LEWIS PRISON

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I. INTRODUCTION

State prisons in Arizona have experienced problems with cell locks for decades. In 1997, inmates were able to "spin" the lock on a cell at Perryville to allow inmate Leroy Cropper to leave his cell to stab correctional officer Brent Lumley to death. *State v. Cropper*, 68 P.3d 407 (2003). A 2006 video from the Department of Corrections' own website demonstrates how inmates at Lewis Prison can tamper with their cell doors so that they can later open them. *Security Alert and Video* August 21, 2006. But the phenomenon was largely unknown to the public until, on April 24, 2019, Phoenix ABC Channel 15 aired a story about non-working prison-door locks, accompanied by video bootlegged from Lewis Prison. Viewers watched, shocked, as inmates streamed from their cells on December 30, 2018, to attack vastly outnumbered correctional officers.

In light of this video, the Governor's Office asked the investigators to provide "an independent, third-party review into matters of security at the Arizona Department of Corrections" ("ADC"), and specifically to "provide an assessment of problems related to cell locks at Lewis Prison." We were asked to produce a timeline relating to "the ineffectiveness of locks at Lewis Prison" and to address how long inmates have been able to open supposedly secured cell doors; what caused the problem; the steps ADC has taken to address the issue; and what proactive measures the state should take moving forward.

We were also asked to examine documents and view video evidence relating to assaults on inmates and staff resulting in serious injury that occurred between January 1, 2018, and April 30, 2019, and then to analyze ADC's actions in reviewing these incidents and the actions it took to prevent them from occurring again. For each incident, we were to ascertain, if possible, whether ineffective locks contributed to the conditions that gave rise to the assault. The contract also requires that we "review management decisions made by agency leadership" concerning accountability for oversight of the safety and security of the inmates and staff as they related to the ineffectiveness of locks at Lewis Prison. Finally, we were asked to provide recommendations for further action.[1]

Although a contract for services was not signed until June 18, 2019, we had agreed to undertake the case in May and began work on May 22.

This report sets forth the process we followed and the steps taken to secure relevant information, provides a timeline of events, and then addresses the questions posed. It concludes with observations and recommendations for consideration.

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[1] On August 9. 2019, just prior to the submission of this report, Charles Ryan announced his retirement as Director of the Arizona Department of Corrections.

II. PROCESS

A. Interviews

We formally interviewed the listed 22 people on the dates indicated, and we talked informally to several others. Only one person, former Lewis Warden Berry Larson, failed to respond to requests for an interview.

June 10:

- Terry Stewart, former Director of ADC; Director during design and build of Lewis Prison.
- Charles Ryan, Director, ADC, 2009 - present.

June 12:

- Gabriela Contreras, Correctional Sergeant who released videos to ABC Ch. 15; assigned to Lewis prison, 2017-2019.

June18:

- Tara Diaz, Southern Region Operations Director; Deputy Warden at Lewis, 2010-2012.
- Carson McWilliams, Division Director of Prison Operations, 2014-2019.
- Daniel Walker, Major at Lewis Prison; Complex Chief of Security.
- Shaun Holland, Correctional Administrator I, 12 years at Lewis Prison in various capacities.
- Ernie Trujillo, Northern Region Operations Director, 2014-2019.

June 24:

- Donna Hamm, founder and executive director of Middle Ground Prison Reform.
- James Hamm, Program Director at Middle Ground Prison Reform.
- Luis Matos, Correctional Captain and Chief of Security at Morey Unit, 2010-2014. Assigned (as Lt.) to Morey; returned to Morey Unit as Captain in 2018.

June 25:

- Mike Landry, ADC Facilities Administrator.
- Jake Gable, ADC Planning Budget Research Administrator.

June 26:

- <u>Randy Standridge</u>, Lewis Complex Major, 2016-2019.

July 8:

- <u>Kevin Tynan</u>, ADC Engineering Facilities Project Manager.
- <u>Luis De La O</u>, COIII, Disciplinary Coordinator, Lewis Prison.

July 10:

- <u>Gilbert Orrantia</u>, Director, State of Arizona Department of Homeland Security; member of State advisory committee following April 24, 2019, airing of the ADC video.
- <u>Mark Hasz</u>, Correctional Lieutenant, assigned to Morey Unit, Lewis (currently at Buckley Unit).
- <u>Travis Scott</u>, Deputy Warden at Stiner Unit, Lewis Prison, 2014-16; DW at Morey Unit, Lewis, 2019-present.
- <u>Chris Moody</u>, Warden, ret., Lewis Prison, 2014-2017.
- <u>Darren Sikes</u>, AZCPOA President, COII with ADC.

July 31:

- <u>Waldemar Mehner</u>, FOP President (telephonic).

August 8:

- <u>Charles Ryan</u>, Director, ADC, follow-up interview.

B. <u>Documents Reviewed</u>

We reviewed several categories of documents, some provided by ADC employees and some provided by others. The following is a partial list.

1. Materials contained on 10 flash drives, including ADC Department Order Manual, General Post Orders, Administrative Inspections of Incidents (Jan. 2018 – 2019), Criminal Investigations 2018-2019, GAR Reports, 703 Reports, Incident Command Reports, Security Device Incident (SDI) Reports, Warden Reports, Significant Incident Reports, Performance Observations (May 2019 re Larson, Ramos, etc.), Lewis Prison Inmate Lock Tampering and Cell Door Malfunction Timeline, emails, media materials, assignment lists, Incident Actions Plan for Morey Inmate move, work orders, Security Device Deficiency (SDD) Reports, videos of assaults and inmate movements, including 11/8/18 Rast Unit fire and 5/10/18 assault on COII Radke.

2. Materials provided by ADC through requests to General Counsel Brad Keough (many provided by flash drive and included in the drives mentioned in #1):

a. Materials relating to ADC budget, including materials provided by Jake Gable: ADC Capital Improvement Plan, Prison Facility Locking Systems Requests 2011-2020 (126 pgs.), legislation relating to Locking Systems Requests, legislation staffing report.

b. Organizational charts, media materials, Lewis Prison Unit opening and warden documents; information on inmate moves; information on "Inmate Assaults on Staff-TOTALS" statewide, "staff assaults FY05-FY19" by prison unit, prison staffing documents, average daily inmate populations, information on Lewis staffing.

c. Information relating to the pinning and padlocking decisions.

d. Information related to assaults resulting in serious bodily injury, including video and investigative reports for the 2/27/18 assault on Inmates Mallory and Mattia; 6/6/18 unwitnessed assault on Inmate McCormick (video of area outside cell); 9/29/18 assault on COII Peralta; 10/5/18 assault on COII Ballentine; 10/20/18 assault on COII Pasos; 10/29/18 assault on COIIs Garza and CO Avila; video, investigative report, Inspector General's Report; 11/22/18 assault on Sgt. Markowski; 12/30/18 assault on COII Nash. We also reviewed investigative reports for the 1/9/18 assault on Inmate Bologna; the 3/25/18 assault on Inmate Johnson; 4/11/18 assault on Inmate Lewis; 6/8/18 unwitnessed assault on Inmate Olvera; 6/27/18 assault on Inmate Ellis; 8/13/18 assault on Inmate Mirza; 10/13/18 assault on COII Garcia; 11/11/18 unwitnessed assault on Inmate Bociung; 12/4/18 assault on Inmate Valdez; 12/23/18 assault on Inmate Espinoza.

3. Materials Provided by Dir. Charles Ryan: CO Vacancy Rate Charts and staffing reports, CR Diary entries, media reports, part of a report re ADC initiatives to reduce staff assault (including Strategic Initiative A3 Project), Information Report 19-L05-00201, -00203, 00207,-00152; 19-L23-001182-01180, and Administrative Inquiry (Contreras), booklet of Prison Aerials (contains aerials plus maps and internal pictures of cells, pods, housing units of various custody levels—Tents, Dormitories, pods, minimum, close custody, old max custody [cell and pod], new max custody, organizational chart, budget documents (FY 2020 Building Renewal Plan, FY2021 Capital

Improvement Plan, FY 2021 ADOA Capital Building Renewal Request Summary, ADC 2017-2019 Appropriations Report, 2010-2020 Capital Appropriations Summary, budget emails, ADOA FY 2020 Capital Improvement Plan), ADC Institutional Capacity and Committed Population Charts.

4. Miscellaneous media clippings.

5. Emails from Tara Diaz re assaults of COIIs Nash and Duran.

6. Letter forwarded by Dianne Post from Keith Nance, #168108.

7. Materials provided through Governor's Office: Senior Staff Briefing May 6, 2019.

8. Materials from Martin Bihn relating to the Investigation of Death of Inmate Andrew McCormick, #228881; redacted AAIU Investigation and other reports, 311 pages; complaint in *Russett v. State/Ryan*, filed 5/9/16 asserting claims against ADC by COs injured by inmates, several of whom were able to get out of their cells, 57 pages; Order in *Russett v. State/Ryan*, 17 pages; Order in *Russett v. State/Ryan*, 18 pages; investigative report re death of Inmate Miguel A. Camacho #167996; 5 Inspector General Supplemental Reports; Information Reports re video footage; Use of Force Report/ICR; SIR; Use of Force/ICR, etc.; total 88 pages of reports; Scientific Examination Report plus other reports re Camacho Death, 101 pages; email from Lance Bevins, 19-year ADC CO who allegedly was injured in 7/12/14 as a result of inmates' ability to get out of cells.

In addition to the foregoing documents, we viewed aerial photos of Lewis and other prisons, "pins" and chains, and videos and photos of prison door locking systems and general inmate movement out of cells.

III. TIMELINE

To place the events that led to this investigation in context, we developed the timeline below. Although numerous incidents contributed to the problems Lewis Prison experienced with inmates leaving their cells, the following list of events includes those most closely related to the subjects of this investigation.

1998

- Lewis Prison opens the Stiner Unit
  - 1999: Lewis opens Barchey and Morey Units
  - 2000: Lewis opens Buckley and Bachman Units
  - 2002: Lewis opens Rast Unit; Rast Max opens in 2014

2002

- 2002 Lock Assessment Report for Arizona Prisons
  - No recommendation for Lewis Prison Locks

2003

- First mention of inmates accessing doors at Lewis

2006

- Lewis Security Alert and video demonstrating how inmates can obstruct doors
- FY 2006: Legislature swept 595.5 FTE positions from the ADC, including 565 authorized Corrections Officer positions, to provide a salary increase for filled CO positions in FY 2007

2010

- FY 2010: The legislature mandated a general 5 percent FTE position reduction by February 1, 2010. The result for ADC was to eliminate 487 positions, including 51 maintenance-related positions. The positions eliminated were vacant; ADC funding was not affected.

2012

- 293 CO positions authorized when legislature added 4,000 prison beds

2013

- 103 CO positions authorized as part of a 3-year plan; the latter years were not funded

2010 to **2014**

- Problems noted with doors at Lewis, particularly the slider doors
  - Reports also note that the control panel showed some cell doors as secure when unsecure and as unsecure when secure
  - Inconsistent reports as to the extent and cause of problems with the doors

2016

- August 21: Security Alert issued re inmates compromising security of cell doors by obstructing; COs told to make visual inspections
- Multiple work orders written directing doors to be repaired

2017

- By fall, general agreement that inmates leaving their cells without permission had become a problem
- August or September: Began discussion of using pins on doors at Lewis
- September to December: Purchased doors pins, chains, steel
- November: ADC timeline states that Director first learned of increase in incidents of witness tampering and cell door malfunctions
    - Director authorized use of pins in the Morey, Buckley and Rast Units

2018

- Pins installed between January and June
    - January 22: Began installation on Morey Unit; completed May 3
    - February 12: Began installation on Buckley Unit; completed June 11
    - June 11: Began installation on Rast Unit; completed June 20
    - Within a short time, the inmates, including porters, would pull the pins, allowing inmates to open "capped" cells
- March: New administrators assigned to Lewis
- September: Director met with leadership and instructed they should be more forceful in enforcing inspections
- October: Director made an unannounced visit to Lewis to inspect the prison and speak with inmates
- By mid-2018, became evident that pinning had not resolved the UA problem
- November 8
    - Fires in the Rast Unit; reports to the Director were incomplete
- December: New leadership team sent to Lewis
    - Instructed to change the culture at Lewis
    - Developed QRF command team to assist COIIs

- December 30: COIIs Nash and Duran-Vargas assaulted by multiple inmates out of their cells

2019

- Installed padlocks on two units of 25 cells each in Morey and Rast; three in Buckley, January to April. Dates installed:
    - Rast: 1/28 and 2/12
    - Morey: 1/24 and 1/30
    - Buckley: 1/3, 2/13, and 4/23
- Introduced stepdown program
- Sgt. Contreras met with superiors and union leadership to discuss assault of COII Nash; she provided videos of that assault and several others, which the union later released to news media
- April 24: News media released video tapes provided by Sgt. Contreras
- April 25: Director authorized use of contingency funds for an additional 825 padlocks for Lewis close custody cells
- April 27: Prison staff directed to file a Significant Incident Report for all UAs; the SIR would go to the Regional Operations Director and then to the Director and the Governor
- April 27-29: Hasps and padlocks installed on all remaining close custody cells at Morey, Buckley, and Rast Blue
- April 29: Governor established review team
- May 6: Began transfer of all inmates from Morey to other prisons; completed by May 15

IV. DISCUSSION: SCOPE AND CAUSES

A. Defining the Issue

Having viewed videos of some of the assaults and fires at Lewis Prison on TV, we thought as we undertook this investigation that there was general agreement that the locks at Lewis Prison were broken. We soon learned that was not the case. There was, and still is to some extent, disagreement about whether the locks are broken such that the doors can't be reliably secured or whether the doors are fine, but the inmates manipulate, tamper with, or "cap" them so that they fail to fully secure. This disagreement helps explain why certain steps were not timely undertaken to remedy the problem of inmates leaving their cells without authorization.[2]

[2] Corrections officers call inmates' leaving their cells without permission or assistance to gain access to the pods or other cells "unauthorized access," or, in shorthand, UA.

The first school of thought, held by much of senior management, from the warden level and perhaps deputy warden level through the Director, is that the doors are not broken. They are, however, subject to inmate tampering. Inmates tamper by placing something – magnets, bottle caps, plastic, or whatever small object they can find – in the door track to prevent the locks on the slide doors from fully engaging, a process called "capping." The doors appear to be closed and may even "click" so they register as "secure" on the control console, but the locking mechanism has not fully engaged and the inmates can later shake or manipulate the doors open. Inmates can accomplish the same end by kicking at, hitting with objects, or otherwise denting the doorframe so that the door won't secure.

If it were the case that the doors are secure unless inmates cap them, then, of course, the doors do not need "fixing," and they certainly don't need to be replaced.[3] Instead, the burden falls to the COs to inspect the door frames more carefully to ensure that inmates have not obstructed them, and then re-check by shaking each door each time they close a cell door to make sure it is fully secured. This view is supported by statements from the lock maintenance personnel who reported to senior management that 70-80 percent of the locks they were called out to repair weren't broken; the inmates had simply capped the doors. Once the obstructions were removed, the doors worked properly.[4]

The second school of thought, held mostly by those who work in the trenches and open and close the doors several times daily, is that many of the doors are actually broken and will not secure. Although the members of this group recognize that inmates do place objects in the frame to prevent securing, this group believes that some of the reason placing the objects can be easily done and affects the doors' functioning is that the doors are getting old and have sufficient "give" in them that they can be manipulated. They respond to the charge that COs are simply failing to adequately check the doors in two ways: First, they acknowledge that sometimes this may be so, but assert that lack of time caused by understaffing leaves them unable to give the extra time that would be required to inspect the frame of each door each time an inmate is returned to a cell and then to shake the door for a few seconds after it has been closed. Estimates of the time this would take ranged from 20 seconds to one minute per door. As a regular part of their work, COs often return 50 inmates at a time to their cells (two to a cell). If they must spend an extra 20 seconds at each door of 25 cells, they have just built in an extra eight minutes[5] into

[3] This is part of management's explanation for not seeking funds to replace the doors earlier.
[4] An inquiring administrator might regard the 20 to 30% of locks the lock repairman reports as actually being broken as a sufficient percentage of broken locks to raise concerns in a prison setting.
[5] 20 seconds times 25 cells = 500 seconds. Divided by 60 seconds per minute, the added 20-second intervals per pod add 8.33 minutes.

that task of returning inmates– which must then be repeated to let the next pod of inmates out for or return from meals or recreation or programming. Delays of 16 minutes here and there add up to delays of an hour or more, and delaying taking inmates for their necessary meals, showers, phone calls, recreation, visitation, classes and other activities makes the inmates dissatisfied. One Lieutenant estimated the time necessary to do a careful lockdown and inspection at one minute per door. Adding one minute per door increases inmate movement time by 25 minutes per pod for each inmate-pod movement, a number that would add delays of a couple of hours in a CO's day. If a CO finds a problem with a door, additional time is spent writing the required report and work order. Second, diverting attention away from the inmates being locked down poses a security risk.

After much discussion and consideration of the positions advocated by the interviewees and after viewing several videos of the doors in action, we concluded that the truth lies somewhere in the middle of the opposing views. It is clear that the inmates do cap and manipulate the doors. Evidence of this has been presented time and again. Indeed, even ADC's own website contains a video made at Lewis Prison in 2006 demonstrating how the doors can be obstructed, register as "secure" on the control panel, yet be able to be opened. But it also is clear that some of the locks are just broken, as evidenced by the many work orders requesting lock repairs that must be serviced or fulfilled by lock maintenance staff. They simply will not close, lock, and stay locked. Finally, several COs spoke of the sound and feel of the doors. As doors get older and start to deteriorate, they become more difficult to close, may stick, and fully secure less and less often. Lewis Prison was built in the late 1990s. The doors are now 20 years old. While that is relatively new in the context of Arizona prisons, the doors get much use, and their proper functioning is essential to safe, secure prisons.

So despite initial disagreement about whether the doors are broken, consensus has now been reached that not all doors effectively and reliably close, lock, and secure the inmates. The inmates' ability to UA their doors presents an untenable security risk that must be remedied.

B. Scope of the Inmate UA Problem

We attempted to determine the scope of the problem – that is, the frequency with which inmates left their cells. But we found that Lewis records are not sufficiently complete to make an accurate determination possible. One supervisor with extensive experience in reviewing reports of inmate UAs estimated that from 50 to 70 percent of such incidents were not reported. Our review of various reports and then viewing related video appeared to confirm that observation. For instance, a report from the warden to the North Regional Operations Director on July 18, 2018, referred to "a number of unwitnessed

assaults" that had recently occurred in cells, but reports of numbers of such assaults could not be found. Certainly COs reported a number of inmate UAs, but no written reports reflect the large number of UAs described by those with whom we spoke.

Several explanations exist for the failure to report. Some COs apparently concluded that filing disciplinary reports for inmates out of their cells was a waste of time because meaningful inmate discipline was not likely to occur; others failed to file reports because they did not have time to do so; while still others may not have wished to incur the inmates' wrath for strictly adhering to discipline protocols. Other COs stated that supervisors told them not to file disciplinary reports or reports for non-locking doors if the inmates returned to their cells when ordered to do so. Failure to report did not end with the COs. We found numerous examples of reports by deputy wardens and wardens that failed to accurately and completely describe an incident entitled to attention from leadership. The net result of these failures is that obtaining an accurate picture of the extent of inmate activity is not possible based on the reports filed.

The failure to report and failure to file complete, detailed reports involving security devices may derive at least in part from the fact that the COs do not have access to an electronic reporting method and so record handwritten entries in their Correctional Logs using Form 105-6. See Arizona Department of Corrections Department Order Manual, Chapter 700, sec. 1.1.3. Initial reports following up are often hand-written as well. Information in them therefore is not available to automatically populate later reports, so time is wasted – and the possibility of error creeps in – as information is re-written on later-stage reports. The additional time required to produce reports under those circumstances makes producing a complete record less likely.

In addition, COs do not communicate with first-and second-line supervisors by electronic means. When information must be transmitted quickly, transmission must take place through telephone calls, radio transmissions, or hand-delivery of written documents. Only the latter provides a record of the substance of the communication. Particularly in situations in which conveying information quickly and accurately is important, a secure messaging or email system would be useful.[6]

Because of deficiencies in the reports, we were not able to fully document the scope of the problem.

[6] We recognize that security concerns in the prison militate against providing COs personal devices that are internet enabled, unless there is adequate security.

C. Causes of the Inmate UA Problem

Even taking into account the difficulty with the doors, a situation that exists to some extent at other prisons, the inmates' freedom to UA their cells at Lewis appears dramatically worse than it is elsewhere in the system.[7] We attempted to ascertain why, and concluded that the ability of inmates to leave their cells without authorization cannot be attributed to any single factor. Rather, a confluence of factors, some of them existing in the prison system and magnified at Lewis prison for many years, coalesced to create the current situation.

1. Status of Locks

When we began this review, we anticipated we would find that the inmates' ability to leave allegedly secure cells resulted from failures of outdated, non-functioning doors and locks. As noted above, however, we learned that, although the age of the doors and locks and the lack of sufficient preventative maintenance contributed to the situation Lewis faced, for much of prison management, the inmates' ability to manipulate the doors was of greater concern in 2017 and 2018.

For many years, inmates in Arizona's prisons have found ways to defeat the locking mechanism of cell doors. At Lewis, the inmates learned to "cap" or manipulate their doors. The impact of capping was magnified by the fact that, for reasons described below, a CO frequently made only a cursory check and did not remove the item, making unauthorized access possible. The status of the locks therefore contributed to but does not entirely explain the ability of the inmates to leave their cells.

2. Staffing Issues

Most of those with whom we spoke identified staff shortages as a major reason for lack of inmate control. Our examination of staff levels from FY 2005 to the present confirmed that ADC staffing, particularly for the COII position, has often been substantially below the level ADC considers adequate for safety and control.

Several legislative actions affected staff levels. The first occurred in FY 2006, when the legislature swept 565 CO positions to fund a pay increase for

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[7] During the course of interviews, we were told that the prisons at Winslow, Tucson (Cimarron and Rincon Units), and Yuma also experience lock problems, although not to the extent that Lewis Prison does. Yuma Prison features the same model of doors used at Lewis but does not have the same problem with mass inmate exits, perhaps because it has a far lower vacancy rate for COIIs. Perhaps the most high-profile failure was the 1997 episode from Perryville Prison reported in *State v. Cropper,* in which an inmate got out of his cell and killed Correctional Officer Brent Lumley.

the occupied positions. The impact at Lewis Prison was to reduce authorized CO positions from 1,035 in FY 2005 to 936 in FY 2006, even as the average daily inmate population increased, and left fewer COs available to oversee more inmates at Lewis and statewide. (See Attachment 1.)

The next impact on authorized positions occurred in FY 2010, when the legislature mandated a 5 percent General Fund Full Time Employee (FTE) reduction across all State agencies. For the prison system, that mandate resulted in a loss of 487 FTE positions, including 113 supervisory positions and 51 maintenance positions. Then, in FY 2012, partly in response to adding 4,000 state prison beds, the legislature authorized an additional 293 COs. (See Attachments 2 and 3.) Finally, during FY 2012 and 2013, additional CO positions were authorized, leading to an increase at Lewis of CO positions from 861 in FY 2011 to 916 in FY 2014. (See Attachment 1.) At Lewis, both authorized and filled positions reached their peak in FY 2016, when the prison had 1,038 authorized and 957 filled CO positions. *Id.*[8] During those years, the average daily inmate population also increased, from 4,688 in FY 2006 to 5,769 in FY 2016. *Id.*

Lewis was designed for staffing of 30 COs in each unit, but Warden Larson reportedly cut staffing to 21. On some days, the units operate with far fewer. In extreme situations, such as days on which a large number of COs "call-in" asking to be excused from duty or days with a large number of inmate medical visits or programming activities or other CO assignments, staffing can be as sparse as 15 to 16 COs. The shortage of staff poses dangers to the COs who often have to work without ready back-up, and it predictably led to various problems. First, as noted in Section IV.A above, the short staffing left less time for COs to carefully inspect each door frame and shake the door to ensure that it was secured as they removed inmates or returned them to their cells. Staff also hesitated to hold inmates accountable because (a) they feared a physical response from the inmates and lacked sufficient backup from other COs on units also short-staffed and (b) they did not want to spend time completing the paperwork required to impose discipline.

Second, the FY 2010 loss of maintenance positions directly reduced the staff time available to repair doors and nearly eliminated the time available for preventative maintenance. Those responsible for completing and supervising maintenance emphasized that the few remaining maintenance staff simply did not have sufficient time to inspect the doors for flaws or to

[8] Although several administrators tied low staffing levels to the reduction in FY 2006, in fact neither Lewis nor the statewide system ever filled all authorized positions. Vacancy rates vary considerably, from 2.5 percent statewide in FY 2007 to a projected 19.7 percent in FY 2020, corresponding with the five hundred and one thousand authorized positions that have remained vacant each year since 2015. If ADC were able to fill those positions, most of the staff shortage would be eliminated. See Attachment 2.

document the repairs that were made. Several supervisors described the door crews as losing motivation because they knew they could not complete their work.

Third, staff shortages negatively affected training new COIIs. The high turnover resulted in having fewer experienced officers, which meant that less time was available to train, and the training that was done was performed by less seasoned officers. The lack of training, in turn, meant that new COIIs were less able to effectively handle difficult situations with inmates.

The impact of understaffing was, in the view of at least one supervisor, exacerbated by the decision to move to 12-hour shifts. Eventually, he said, experienced staff simply burned out and left, making training ever more difficult to accomplish.

3. Staff Morale

Nearly everyone with whom we spoke, supervisors and COs alike, agreed that staff shortages eventually affected staff morale and resulted in staff not completing security checks of cell doors. They suggested that, faced with too little time to complete their tasks, the COs either gave up or became complacent. Complacency became a particular problem after pins were installed in 2018, as some staff relied upon the pins to secure cells and became less concerned about making certain the inmates had not capped the doors. Others believed that staff failed to check doors properly either because they had never been properly trained or because they just became lazy. Others suggested that, for security reasons, a number of the COs were afraid to confront inmates, so they chose to allow the inmates to act as they wished. Whatever the reason for individual officers, the failure of the COs to make sure the doors were secure and not obstructed resulted in inmates being able to leave their cells almost at will. Inmates being outside their cells became a daily occurrence. As this spiral of indifference by COs and bad behavior by inmates continued, the morale of the COs dropped.

4. Leadership

Many of the issues involving COs could have been corrected or at least alleviated with better leadership. Several COs and persons in lower supervisory positions told us of instances in which leadership failed to hold those whom they supervised accountable for failing to complete their duties. We heard of supervisors who told COs not to complete required reports or to obstruct rather than disclose incidents that could be seen as reflecting badly on those in charge.

We found a general, although not universal, concern that the COs could not depend upon leadership to support them. We heard criticism about

supervisors who spent most of their time in an office rather than being on the floor, where they could support and help mentor and train the COs – and learn about what was going on in the pods. Several persons were particularly critical of the Lewis leadership during 2017 and 2018.

Several members of upper management suggested that the problems existing at Lewis in 2017 and 2018 are traceable at least in part to the lack of quality staff and leadership from the time the prison opened. They explained that, to convince staff to come to Lewis, persons who otherwise would not have qualified for promotions received them on the basis of only an oral exam. That view is not shared by all; we also heard that the initial staff included some seasoned and capable deputy wardens, wardens, and captains. If the failure of initial leadership had been as extreme as some suggested, we would have expected problems to have developed sooner than they did. Inmates could have tampered with the locks by obstructing them at any time. It seems unlikely that the issues of 2017 can be closely traced to leadership issues in 1998.

The conclusion we heard from some, that leadership and prison management had completely broken down at Lewis by 2018, may be extreme, but does reflect the level of frustration we found.

5. Prison Gangs

The consensus of those with whom we spoke was that, although inmates had been able to UA their cells for many years, doing so did not become a real problem until late 2017 or 2018. We asked each interviewee what happened in 2017 to cause a change, and most did not provide an explanation.[9] Some mentioned the lack of leadership, discussed above. One person noted that, in 2017, participation in prison gangs became noticeably more prevalent, and communicating with gang members or reaching members of competing gangs provided motivation for the inmates to leave their cells and enter others. That situation would have been aggravated by the fact that the gang unit failed to validate[10] any gang members for more than a year, thus failing to provide the information needed to move suspected gang members to another unit or complex.

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[9] As noted elsewhere, some of the interviewees believe that serious problems with locks did not develop until 2018.

[10] Validation is a process for determining whether an inmate is affiliated with a prison gang. Once an inmate is validated as a gang member, the inmate may be transferred to a different prison or to a higher security level.

6. Pinning Cells

Ironically, one of the steps ADC took to keep the inmates in their cells may have actually increased the frequency of UAs. That was the decision to use pins, or hasps, on the doors in the Lewis close custody units. The pins are 8-inch steel rods attached to chains and welded to the door frame. Once a cell door was closed, the pin could be inserted through metal brackets that were also welded to the doors. The pinning procedure was intended as a redundant security system, not a primary one; the primary system remained the locking mechanism on the door. But because the pins were in place, COs may have become complacent about ensuring that the doors were fully secured before pinning. Interviewees reported that adding the pins angered the inmates, who responded by having "pod porters," inmates who were allowed out of their cells to perform specific functions, remove the pins or by breaking their cell windows and removing them. So a system intended to remedy UAs may have exacerbated the problem and have been a cause of the upswing in mass inmate UAs.

V. EFFORTS TO ADDRESS DOOR AND LOCK ISSUES AT LEWIS PRISON

After the videos of assaults at Lewis aired, ADC responded to media questions about why inmates were able to leave their cells and why effective preventative actions had not been taken by the Department. In its initial response, the Department indicated that Director Ryan was not aware until May 2018 that Lewis had experienced a "material increase" in the incidents of inmate lock tampering and cell door malfunctions. Shortly thereafter, the Department corrected its statement to indicate that the Director became aware of inmate tampering and lock malfunctions in November 2017 and immediately took corrective action.[11]

Once ADC leaders acknowledged that having prison cell doors that inmates could "access" or open without authorization posed a safety risk for staff and inmate safety, they took several steps to mitigate the problem.

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[11] In its statement, the Department apparently distinguished individual instances of inmate lock tampering, which the Department recognizes have occurred for decades, from some other type of material increase "in the incidents of inmate lock tampering and cell door malfunctions." The Department may be suggesting that the increase it noted was in cell exits involving more than one or two inmates. If so, we do not find documentary evidence to support that distinction, although we recognize that the reports of UAs may not include all instances of mass exits.

A. Pinning the Doors

The first and most aggressive step the Department took involved pinning the cell doors at Lewis.[12] Pins apparently were authorized in November 2017 and installed between January and June 2018 in the Morey, Buckley, and Rast Units at Lewis Prison Complex.

During our interviews and review of documents, we examined both when ADC made the decision to place pins in the Lewis cells and whether ADC records support the stated justification, that a material increase in incidents related to the doors and locks occurred in 2017. We examined reports that should reveal whether a material increase in incidents occurred and spoke with personnel involved with the decisions of whether and when to pin the doors.

1. Timing of the Decision to Pin Doors

Given the importance of the Department's decision to pin the doors, we expected to find detailed information about the reasons for and timing of the decision. Instead we found limited records that raise questions about both the timing and justification for the decision to pin.

Although the Lewis records for 2017 do not include frequent discussions of whether to pin doors, we did find some evidence of discussions of the pins in the months before the Director says he first learned of UA problems. In a September 19, 2017, memo, Deputy Warden James Roan reported to Warden Larson that staff "have been advised during the DW-COII meeting that a 'pin' system will be installed eventually. Until then, emphasis will be put on the timely submission of work orders and follow-up for completion." The timing of this statement is consistent with the memory of several supervisors at Lewis who recall being sent to the prison complex in Winslow during the summer of 2017 to learn about installing a pinning system. These supervisors believed that the move toward pinning was attributable not to any big increase in UAs, but rather to the fact that the then-current Northern Region Operations Director (NROD) had used pins previously and supported that approach. Purchase records show total expenditures of $9,080.63 for pins, chains and steel between September and December 2017.[13] Minutes of a meeting held by Warden Larson on November 2, 2017, state that Morey will be the first unit to have pins installed, suggesting again that the

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[12] As explained earlier, see § V.F, pins are 8-inch steel rods attached to chains and welded to the door frame. Once a cell door is closed, the pin is inserted through metal brackets welded to the doors.

[13] Most of the funds involved, $6,100.00, were authorized by the Director on December 19, 2017.

decision to pin had been made before November 2017 and without any mention of a material increase in UAs.[14]

2. *Motivation for Pinning: Did a "material increase" in Inmate UAs Occur before November 2017?*

ADC attributes the decision to pin the doors to a "material increase" in inmate UAs. We attempted to verify that assertion.

ADC has adopted a comprehensive set of Department Orders that direct the filing of a number of reports when staff members note deficiencies in security devices, which include doors and locks. See Arizona Department of Corrections: Department Order Manual (Order Manual), Ch. 700, sec. 703. We reviewed hundreds of pages of those reports, beginning with 2017, in an attempt to identify any point at which UA incidents materially increased. While, as noted elsewhere, these reports are not always complete or sufficiently detailed to be entirely confident of conclusions based on them, the reports provided us show examples of UAs in 2017 but do not, on the whole, support the notion that incidents materially increased during the latter part of 2017.

The report most closely related to our inquiry appears to be that required of the Chief of Security or his or her designee, who must file a monthly report describing security device deficiencies and the actions taken to repair those deficiencies. Order Manual, Ch. 700, sec. 1.1.3. Looking first to the reports for the Morey Unit, the report for February indicates that some cell doors show unsecure on the control panel even though they are secure, and reports for the next several months describe problems with slider doors. Several mentions are made of cell doors that can be opened, with reports of multiple doors that can be opened in March and June, but only two being mentioned in July and four in September. Not until the middle of November, after the Morey staff had been told that pinning would begin in that unit, does this report list a substantial number of doors that can be opened from the inside. The November report lists 40 doors that can be opened, with work order repair dates ranging from November 18 to November 27.[15] The December report indicates that all the cell door deficiencies noted in November had been repaired.

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[14] We requested any memoranda or orders from the Director ordering the installation of pins, but none was provided.

[15] The more detailed reports may be related to the finding of the Inspector General Bureau Audit Unit's Annual Audit Report for ASPC Lewis, which found that neither the Morey Unit nor the Stiner Unit could show completion of the required monthly comprehensive security device inspection by the Chief of Security. See 2017 Annual Audit for ASPC Lewis (August 2017) at 79, 112. In fact, the Audit Report noted, the Deputy Wardens, Associate Deputy Wardens, and supervisory staff did not submit the required 703 reports to the Warden or Regional Operations Director on a monthly basis. Audit Report at 3.

The reports for the Rast Unit follow much the same pattern. For January through April, the main concern expressed about cell doors is that approximately 16 show unsecure on the control panel when they are actually secure. Two doors, the report notes in January, can be opened by inmates. The May report notes one door that can be easily opened but does not show unsecure; July notes one cell door will not close. For those months, the report also notes problems with some sliders. By October, the report notes two cell doors will not secure and seven show unsecure. By November, eight cell doors can be opened from the inside but show secured. And, by December 20, 2017, the report notes 13 doors that can be opened from the inside and 16 malfunctioning doors. These reports, while they reveal the ongoing problem with inmates being able to open their cell doors without authorization, do not show a material increase in such activities in September through October that would prompt a decision to pin in November 2017.

But other reports could have been more specific in reporting problems with cell doors opening. The Order Manual also directs the Warden to submit a monthly memorandum to the NROD; among other topics, the memorandum covers observations about security operations, the incident command system, and staff professional conduct. Order Manual, Ch. 700, sec. 2.3.1. That report made no mention of cells or locks in January 2017, although three inmates were assaulted in their cells, and two died. In February, the report notes that the Stiner run "began to fill with inmates" and that Rast has adopted enhanced cell procedure to combat inmates who UA their doors. The report does not report problems with doors or locks from March through May, although two more inmates died from assaults within their cells and another was found unresponsive. The June report notes another inmate assaulted in his cell and reprimands a COII who allowed pod doors to be unsecure with multiple inmates out. The July report notes that a large group of inmates became combative and began striking staff members and that another group simultaneously broke the trap doors on their cells in Stiner Detention. The August report notes that approximately seven inmates were involved in an assault on another, who told staff they "popped" his door. The September report, however, includes nothing relevant to this issue. In October, the warden notes safety concerns at Morey related to current staffing levels and reports an ICS called involving the death of Inmate Diaz. In November, the warden reports that additional staff at Morey has helped morale tremendously and that there has been a marked decrease in assaults.

We also examined other documents in an attempt to define the reasons for the decision to install pins at Lewis beginning in January 2018. We requested and reviewed minutes of meetings held by the respective wardens at Lewis. The minutes from the Warden's meeting with COIIs on August 30, 2017, reflect that doors are "constantly breaking" and that Lewis has two dedicated officers working every day to make repairs. On the same day, in her meeting with the Lieutenants, the Warden "demonstrated the proposed new

door locks for close custody cells." In her meeting on November 20, 2017, the warden discussed the upcoming door control job schedule. Although the minutes demonstrate awareness of the problems with the doors, they do not help to define that point at which issues involving these security devices materially increased.

We also requested that the disciplinary coordinator assemble all Inmate Disciplinary Reports related to assaults, beginning in 2017. If an inmate UAs his cell, a disciplinary report should be filed. Although we learned that the COIIs often did not institute disciplinary proceedings, those that were filed should provide an indication of whether and when UAs increased. Those incident reports also do not reflect a pattern of increased activity during 2017. Most of the assaults that resulted in discipline do not involve an inmate leaving a cell without permission. The number of such incidents ranged from one in January, August, October, and November to four in May and two in December.

The reports we reviewed show a relatively consistent level of UAs, with some months experiencing a higher activity level than others. None of the reports we reviewed provide substantial support for the statement that pins became necessary in late 2017 *because of* an increased incidence of inmates leaving their cells or *because of* a notable increase in doors malfunctioning. If pins were indicated by the end of 2017, presumably that same decision would have been justified earlier in the year.

3. Success of the Pins in Remedying UAs

The decision to use pins did affect the frequency of UAs and staff and inmate assaults. The effect, unfortunately, was to increase those incidents. Interviewees reported that adding the pins angered the inmates, who responded by having "pod porters" remove the pins or by breaking their cell windows and removing the pins themselves. So a system intended to remedy UAs may have instead exacerbated the problem.[16]

Monthly reports from the warden to the NROD clearly reflect the continued and growing struggle with inmates pulling pins and with failing doors. *See, e.g.,* Warden to NROD Memoranda, March 2018 (unit doors constantly failing or being manipulated by inmates; many pins do not engage); May 2018 (unit doors constantly failing or being manipulated by inmates; porters continue to unpin; too many cell doors open); June 2018 (inmates still capping cell doors and intentionally bending pins; porters continue to unpin; too many inmates left out and unsecured); July 2018 (inmates capping, manipulating, intentionally bending pins; some doorways out of alignment;

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[16] The pins were a failure in another significant respect as well. The inmates learned that by pulling the pin inside the cell and slamming the cell door, they could break the chain, leaving the inmates with, in essence, an 8-inch metal shank – a dangerous weapon. The work order documents reflect pins missing from several doors, and time and effort was expended by COs trying to retrieve them.

unwitnessed assaults; staffing level; decreasing performance and increasing turnover rate); August 2018 (multiple ICSs due to disruptive inmates that pulled door pins and refused to lock down); September 2018 (inmates continue to unpin and UA); October 2018 (doors easily opened by inmates; maintenance issues and manipulating by obstructing; inmates have destroyed much of secondary pin system; inmate UAs a danger to staff and other inmates); November 2018 (same concerns as voiced in October; UAs have resulted in numerous ICSs and a draw on staff resources); December 2018 (cells doors continue to be a problem; inmates, despite pins, still able to access doors with impunity; door pins of little value; doors go through various stages of degradation).

The frequency of assaults against officers and inmates also increased, particularly in the last half of 2018. During the first six months of 2018, five incidents involving serious injury occurred at Lewis, with three involving unwitnessed assaults on inmates and two inmates assaulted outside the cells. From July through December, four more inmates suffered serious assaults, one unwitnessed inside a cell. There were also seven incidents of staff assaults during that time, some involving injury to more than one officer. A video of the last 2018 incident, involving COII Nash on December 30, 2018, was distributed by news media in April 2019.

By mid-year, it was clear that pinning had not resolved the UA problem.

B. Strategic Initiative A3 Project

In January 2019, ADC instituted the A3 Project, which focused on reducing staff assaults. Although not specifically directed toward resolving UAs, the A3 project related to an aspect of the problem. It began as a pilot program at Morey unit and also at Eyman/SMU-I, and ran through March 21, 2019, at which time it was extended for 60 days to gather additional data. The program required interviews of staff and inmates involved in assaults about the causes of assaults. The primary reasons proved to be "ineffective communication and/or approach by both staff and inmates, inmate opportunity to commit the assault (meaning the victim is whoever is present when the opportunity to assault a staff member is available to an inmate), the officer's attitude and/or the inmate's mental health score." The initial 60-day pilot showed fewer reported assaults on staff and the program resulted in two ideas that were implemented: (1) security sergeants walked each pod each day to talk to inmates and document issues to be followed up on, and also to mentor correctional officers, and (2) ADC adopted programs to resolve inmate grievances in the early stages of the process.[17] We cannot determine the effect

[17] These responses come from the answer to question 2 on a 4-page questionnaire produced by Director Ryan at his interview on 6/10/2019. Although the A3 program addresses staff

of these two implemented processes on reducing UAs, although in an August 8 interview, Director Ryan expressed the view that there had been several "quick wins" from making small changes resulting from ideas elicited in listening programs and the direct-line to the Director, ideas generated as a result of the A3 Initiative.

C. New Leadership Team at Lewis

In June 2018, Director Ryan and others made an unannounced visit to Lewis prison. They were dismayed at what they saw – broken windows, laundry strewn around, dirty cells, clotheslines in cells, and general unkemptness. By September, it was clear to prison leadership that the pinning system was failing to secure inmates. These and other observations led the Director to advise the leadership on September 7 to clean things up within three months. But the September 29 assault on Officer Peralta, the November fires at Rast, and other factors, caused the Director to issue an order effective in January 2019 changing the leadership team at Lewis prison.

This included transferring or demoting the warden (transfer effective in December 2018), the deputy warden of operations, four deputy wardens and the Complex Major. Those interviewed generally agreed that the replacement was appropriate and that the new leadership team, though faced with a difficult situation, was taking steps to improve cleanliness, morale, and discipline. The new leadership team has overseen the installation of padlocks on cells, emphasized getting inmates into programs, and created a five-member Quick Response Force (QRF) to respond quickly to security incidents involving assaults, to hold inmates accountable, and to "have the backs" of correctional officers.

D. Command Meeting

In September 2018, Director Ryan called a senior/command meeting during which he ordered more random and unannounced visits to Lewis and directed Division Director of Prison Operations Carson McWilliams and North Region Operations Director Ernie Trujillo, who were to retire within the year, to "'think about replacement leadership' for themselves."

E. Significant Incident Reports

In December 2018, Significant Incident Reports became required for all lock-related issues. These reports go up the chain of command and so are designed to provide notice to higher-ups.

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assaults, not necessarily issues related to inmates being out of their cells, it is included here because assaults are a primary reason for concern about inmates' ability to leave their cells.

F. Padlocking the Cells

Effective January 2019, leadership designated two pods of 25 cells each to be padlocked in each unit (a total of 825 padlocked cells).[18] Inmates who accessed their doors and refused to return to their cells when instructed to do so were placed in padlocked cells. Once the use of padlocks became known, there was pushback from visitors, inmates, fire marshals and others, although the State Fire Marshal and Buckeye Fire Marshal eventually approved temporary use of the padlocks.[19]

Prison cell doors are designed to open automatically from a control center so that several cells can be released or locked at one time. The ability to quickly open cell doors can become important in the event of a fire or other emergency. Although pinning precluded release from the control panel, it nonetheless allowed relatively easy access to cells should inmates need to be released quickly. Padlocks, however, must be individually unlocked, which takes time and may challenge the courage of any CO who must enter a burning unit to unlock inmates' cells. And as with other locking mechanisms, the padlocks were subject to inmate tampering. If locks were left on the doors, inmates could jam the key hole. For that reason, COs were required to completely remove the padlock and carry it away each time they opened a padlocked cell. In rare instances, inmates were able to remove padlocks or find unsecured padlocks, and these could be placed in a sock and used as a weapon. So while padlocks successfully secured inmates in cells, they were heavy, time consuming, and not an acceptable long-term solution.

G. Step Down Program

At some point in 2019, supervisors at Lewis instituted a step down program, which used inmate "leaders" – those who had influence over other inmates – to help control inmate behavior and keep the peace. These inmate leaders were rewarded by extra privileges and withholding discipline. These privileges reportedly made other inmates unhappy. When asked what makes inmates influential, interviewees told us that it was sometimes personality and often because of the inmates' connections, such as gang leadership positions or affiliation.

This model of inmate-on-inmate discipline did not prove successful. Although the paper records show that assaults appear to have gone down in frequency, interviewees told us that the assaults just occurred within the cells (where there are no video cameras) and weren't reported and, with increasing

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[18] The number of padlocked cells has gradually increased, reaching 1,000 cells at Lewis by May 5, 2019.

[19] These responses come from the answer to question 3, pp. 2-3, on a 4-page questionnaire produced by Director Ryan at his interview on 6/10/2019.

frequency, the "discipline" administered by the inmates was physical and severe.

H. Moving Morey Inmates

Starting on May 6 and ending May 15, 2019, ADC moved 716[20] inmates from Morey Unit in order to rehouse inmates who had been in padlocked cells and others, enhance staffing levels, and begin "installment of a long-term solution" – that is, to install doors with a new locking system. This move was recommended by a statewide team formed by the Governor's office to help resolve problems at Lewis prison. Shortly before this mass move, starting in January 2019, 70 "problematic/predatory" inmates from Morey and Stiner were moved to other institutions and other, more compliant inmates were brought in to replace them.

I. National Survey of Locking Systems

ADC contacted several jurisdictions, perhaps as many as 47, about the cell doors and locking systems used in their penal systems to find potential solutions for Arizona's cell door problem. It invited representatives from lock companies to come to Arizona to make presentations about their products. That has occurred, and finalists are being considered.

J. State Team

Although not a response initiated by ADC, following the airing of the assault video on Channel 15 in April 2019, the Governor's office pulled together a team to help ADC assess the situation at Lewis Prison and offer suggestions to help guide ADC through the crisis. The team consisted of Nola Barnes (ADOA), Josiah Brandt (State Fire Marshal), Heston Silbert (Deputy Dir., DPS), Billy Long (Phoenix Police Supervisor, ret.), and Gilbert Orrantia (Dir. Arizona Dep't of Homeland Security). Gilbert Davidson, State COO, also attended many meetings. The group met daily until June 25, including by phone on the weekends. By then, "a rhythm had been established" and the group did not touch base so regularly. This team recommended moving the Morey prisoners, setting up a communications hotline to field and respond to calls regarding the locks situation, and daily telephonic meetings for the ADC leadership team to discuss all problems.

K. Requests for Funds

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[20] Media reports and some internal reports say ADC re-housed 800 inmates, but ADC records from that time report moving 716. Although Morey Unit contains housing for 800 inmates, because 64 beds were already vacant and 20 soon-to-be-released inmates weren't transferred, the correct number moved was 716.

Each interviewee was asked how to remedy the inmate "unauthorized access" issue. Without exception, each mentioned replacing the locking systems with a system not easily manipulated by inmates, while acknowledging the need for the resources to accomplish that task. We therefore looked to see whether ADC had made requests in its annual capital budget submissions to ADOA for funds to repair the locks.[21]

1. ADC Budget Process

ADC's annual operations budget is approximately $1.1 B, much of it allocated to "security." But most of that operations budget is attributable to personnel costs. New capital projects and substantial hardware costs such as those needed to change the locking system must come from the Capital Improvement Program (CIP) funding, building renewal funds, or special appropriations. The capital (vs. operational) budget process for state agencies requires each agency to submit its capital improvement funding requests to ADOA, see A.R.S. § 41-793, so ADOA can consider requests from state agencies as a whole and adjust agencies' budget requests to reflect ADOA's prioritization of statewide capital improvement needs. This process regularly results in agencies' requests being reduced from the amounts the agencies originally sought. With this process in mind, we asked for information on how much money ADC requested each year to repair or replace locking mechanisms at Lewis Complex and also for the prison system as a whole, how much ADOA approved in its Capital Improvement Projects (CIP) requests to the legislature, and how much the Legislature appropriated in each fiscal year (FY) for lock repair and replacement.

2. ADC Requests for Funds for Locking Systems

We reviewed budget submissions from 2005-2020 to see whether the Department of Corrections recognized the need for money to repair locks at Lewis prison and annually requested capital improvement funds for that purpose. Review of the DOC Capital Improvement Plans shows that during this period, ADC annually submitted requests ranging from a low of $28,808,505 (FY 2016, 2017, and 2018) to a high of $65,210,205 in 2009 to repair locking systems in the prison system as a whole. In the ten years the agency has ranked its capital priorities and stated the result of not getting the funds, ADC each year ranked the priority of its locks capital request as either 1

[21] We looked at submissions to ADOA rather than to the Legislature because ADOA may cut the amount an agency requests before it is submitted to the Legislature and we were interested in seeing how much ADC had requested, not how much ADOA chose to pass along. There are, of course, other funding streams that could be accessed to help repair or replace doors. For example, maintenance personnel such as locksmiths repair locks, but are paid out of ADC's operations budget. ADC also earns income from ACI inmate services and labor, and fees raised by charges on inmate banking, phone calls, visitation, and other services. One budget specialist speculated that ADOA Risk Management might be able to provide funds.

(8 times) or 2 (two times), and scored the "impact of failure" of locks as "life safety."

Oddly, however, although ADC leadership recognized the serious issue with broken locks statewide, the Lewis Complex was included in the budget requests for capital improvement funds for "Prison Facility Locking Systems Requests" only in 2011, 2012, and 2013. That is, the Lewis Complex was *not* included in the requests for funds for prison locking systems in 2014, 2015, 2016, 2017, 2018, 2019, or 2020. (See Attachment 4.) This is so even though, by at least 2017-18, assaults and deaths had resulted in part from the ability of inmates to "access their doors" and leave their cells without having the COs open the doors for them, and ADC leadership had acknowledged being advised that inmates' ability to get out of their cells had become an increasing problem.

Review of ADC's FY 2005-2020 Locking Systems Requests Summary shows requests for appropriations for locking systems submitted to ADOA, DOA's adjusted CIP request to the legislature, and the legislature's appropriations (and ex-appropriations). (See Attachment 5.) The document shows recognition by ADC of the serious need for funding to repair or replace locking systems, but a dramatic reduction each year by ADOA from amounts ADC requested, resulting in lower requests being forwarded to the legislature, and low levels of funding from the legislature.

For example, ADC's request to ADOA for capital improvement funds for locking systems in FY 2005 and again in 2006 is $40.18 M. In 2005, ADOA recommended $7.9 M and in FY 2006, $8.5 M. The legislature's appropriation in each year? $0.

That result is not selective. In 13 of the 16 years represented on Attachment 5, the legislature appropriated $0 in response to ADC's CIP requests for Locking System funding. In 2007 and 2008, when ADC requested $47.2 and $55 M respectively and the ADOA CIP passed through a request for $8.5 M, the legislature appropriated $5.2 M, not a bad percentage of the $8.5M CIP request from ADOA – except that in 2008 and 2009, the legislature ex-appropriated (that is, took back) $5.2 M, leaving the cumulative funding during that 4-year period at $5.2, or $1.3 M per year.[22] In FY 2018, when ADC requested $28.8 M and ADOA submitted a CIP request for $7 M for locking systems, the legislature appropriated $1.45 M. In total, over the FY 2005-2020 period, ADC requested $582.6 M. On ADC's behalf, ADOA recommended adjusted CIP requests of $114.1 M, and the legislature appropriated $11.85 M (minus the 5.2M ex-appropriation, so a total of $6.65). To be clear, although

[22] The legislature appropriated $5.2 M in FY 2006 and $5.2 M in 2007 for a "multi-year capital project" relating to "Replace and Upgrade Cell Doors and Locks; Restore Appropriations Phase II." But then in FY 2008 the legislature ex-appropriated $2 M, and in 2009, it ex-appropriated $3.2 M. That ex-appropriation of funds resulted in DOA cancelling "Unit Security Upgrades" at ASPC Florence. 2020 ADOA Building System Cap Improvement Plan, p. 14.

ADC submitted requests totaling $582 M during the 2005-2020 period, that amount does not represent locking-system funding needs, but rather represents an amount inflated by inclusion of amounts resubmitted (because unfulfilled) over the course of several years. Ironically, in one year (FY 2010), ADC submitted a $0 request for funds for locking systems repairs, but it nonetheless received an ADOA CIP recommendation of $5.2. In any event, it received the typical legislative response: $0.

Since FY 2012, although it still makes requests for new capital funding through ADOA, ADC has been authorized to receive building renewal funds directly through dedicated building renewal fund sources. (See A.R.S. § 41-793.01; 2011 sess. law; ADOA FY 2020 Building System Capital Improvement Plan p. 4). The amount of building renewal funds for ADC was to be driven by a formula that should generate approximately $22.3 M annually for capital renewal projects. But according to interviews at ADC, the legislature has funded only approximately $5.5 M annually, or just under one-fourth of the amount ADC should receive under the formula.[23]

ADOA reports that since ADC began receiving direct funds, "ADC has completed locking projects at prison complexes across the state at the cost of $8.81 M and currently has $1,412,29 [sic] in locking projects in its FY 2019 building renewal plan. Estimates for the remaining scope of this funding issue are currently in the range of $35 million to upgrade or replace locking systems at all ADC prison complexes.[24] ADOA recommends several years of funding commitment to a phased approach for multi-complex lock and cell door projects. . . ." (ADOA FY 2020 Building System Capital Improvement Plan, p. 14.) ADOA's recommended appropriation is $7.0 M. In short, there is some recognition that money is necessary to help repair or replace the locking system at the prisons statewide, but the amount necessary for meaningful repair or replacement has in the past fallen far short of what will be necessary to remedy the problem.

This snapshot of the budget process shows that, while ADC regularly requests money for lock system repairs for the statewide prison system, its message was for years not presented forcefully enough and was not getting through, either to the ADOA or to the legislature. The picture presented until mid-2019 is of a somewhat laissez faire attitude by ADC about

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[23] "The Legislature fully funded the Building System's building renewal Formula only once in the last 30 fiscal years (FY 1999)," supporting ADC's assertion that the formula is not fully funded. ADOA FY 2020 CIP Report, p. 6.

[24] Even if ADC receives only approximately 5.5 M per year from this formula-driven fund, that sum, over the six years from 2012-2018 would have generated approximately $33 M. Of that, ADOA reports that $8.81 was spent on locks. ADC does have other serious capital improvement needs, of course, but given its own ranking of locking systems as #1 or #2 during these years, it is surprising that a larger share of funds was not devoted to this critical security need.

requesting/demanding money for locks and security and then, if money is appropriated, actually spending it for that purpose.

On the latter point, we have not been able to determine how much of the money appropriated was spent on the repair and replacement of locks. ADC does employ, among their maintenance staff, personnel who repair locks, and funding for those positions comes through the operations budget. And as noted above, ADOA reports ADC as having spent $8.81 M on locks projects from 2012-2018. But we have not been able to trace the money to particular projects. Nor have we been able to determine why no money was requested for locks at Lewis prison from 2014-2020. Asked about the absence of requests for funds to repair locks at Lewis during these years, ADC explained that it thought that the pinning program it instituted fixed the problem, and so ADC did not request funds for locks at Lewis. As set forth in the timeline, however, pinning was not completed until June of 2018, so that reasoning does not explain the failure to request funds to fix locks at Lewis Prison for 2014, 2015, 2016 and 2017. That absence may be explained by leadership's belief that the inmates' ability to get out of their cells was not attributable to malfunctioning doors prior to the 2017, but rather was caused by inmate tampering; so because the doors did not require fixing, there was no reason to request money for that purpose.

In a follow-up interview on August 8, 2019, Director Ryan noted that the "locking systems capital budget requests for FY 2011 to FY 2020 were originally based on the Arrington Watkins Architects statewide locking system evaluation completed in January 2002. . . . The cell locking systems at the Lewis Prison Morey, Buckley, and Rast Units were not identified in the 2002 Arrington Watkins evaluation as needing repair. Additionally, the Lewis Prison did not request repairs for the locking system as part of the annual capital budget process in years 2014-2020 because the locking systems were functioning as designed, notwithstanding inmate tampering, which led to the pinning and eventual padlocking of the doors in 2018 and 2019, at which time the locking system issues were elevated and included in the agency capital request process for 2021."

In its FY 2020 building System Capital Improvements Plan, ADOA does "recommend[] several years of funding commitment for a phased approach for multi-complex lock and cell door projects," but cautions that "[r]eplacement priorities are subject to change upon further intensive system evaluations." While the latter is of course true, the serious life/safety aspect of functioning doors in a prison should motivate strong commitment to funding this critical need.

At a June 16, 2019, Joint Committee on Capital Review (JCCR) presentation, ADC requested $45.9 M for repairs to occur in three phases to fix the locks, fire alarm and suppression systems, HVAC, and other capital

projects. Although lock-related requests are not broken out in the plan, JCCR gave favorable review for the expenditure of $17.7 M in non-appropriated funds, of which approximately $16.5 M in Phase 1 is intended to fix 1284 locks at Lewis Prison; the extra $1.2 M is for repair of fire alarms and fire suppression systems. ADC and ADOA place the cost of fixing the locking system at approximately $12-13,000 per door. The full project is expected to be completed at Lewis in calendar year 2020.[25]

VI. GRIEVANCES RELATED TO FAULTY LOCKS

Our assignment from the Governor also asked that we determine whether "any staff or inmates filed grievances regarding the ineffectiveness of locks at Lewis Prison during this period of time." Although the time referenced in the contract for most inquiries is January 1, 2018, to April 30, 2019, we requested staff to gather grievances going back to 2017. The existence of frequent grievances by inmates or staff asserting that non-securing doors placed them in fear for their safety could have provided notice to leadership that failing doors presented a security risk.

There weren't many. No inmate grievances were found at Buckley, Morey, Stiner, Barchey, Bachman, or Eagle Point Units. There was one from Rast Unit from 2017. In it, an inmate complained that a control room officer inadvertently opened his cell door, after which he came out of his cell and wandered around the pod and could have caused trouble. This, he claimed, jeopardized his own safety and the public's safety, for which he asked for installation of a pin on his door – and $10,000 compensation. See case no. L21-202-017. The grievance was considered, denied, and appealed. On appeal, the reviewing officer, again denying the claim, noted that the inmate could have simply remained in his cell, protecting himself and the public from harm – from himself. Pins were installed on cell doors in Rast in early 2018, providing the inmate the security relief he sought.

ADC staff located eleven CO grievances involving inmate UAs of their cells. None, however, grieves the fact that non-working locks place the officers' safety in jeopardy, an issue one interviewee said was not grievable. Instead, in most cases reviewed, the officers challenged discipline imposed for failing to follow guidelines in handling or preventing an incident at the prison, most involving observing inmates out of cells and failing to order them to lock down. See, e.g., 2019-0127 (Diaz); 2018-13065 (Markowski); 2018-0911 (Vargas, Garcia, Ravelo); 2018-1228 (Hawley); 2018-0899 (Wagner); 2018-0497 (Vega). In each case, there is evidence that one or more inmates were out of their cells without authorization, but the CO does not grieve the inmates' ability to get out and threaten their safety. Rather, they grieve the discipline imposed for failure

[25] Note again, however, that the recommendation is to allow ADC to spend non-appropriated funds. That is, the recommendation does not include new money. ADC is expected to find the money for Phase 1 in its existing budget.

to follow procedures in returning the inmates to their cells or initiate ICS procedures. Most cases involve fairly minor discipline that would not have risen to upper management levels. For that reason, none of these grievances illuminate the subject of this investigation – that is, providing notice to leadership about the safety threat to COs and inmates posed by the failing locks.

A few of the staff grievances, those relating to Officers De La Rosa, and Mischel Wagner, and Sgt. Brian Devous, involved inmate UAs in the sense that in each, the officer in question forwarded video of incidents that occurred at Lewis Prison through Facebook or other electronic means.[26] In each case the discipline imposed was rescinded. These reports do not involve staff complaints about inmate UAs per se.

In short, no useful information was gleaned by examining the grievances filed by either staff or inmates that would shed light on this inquiry.

VII. ASSAULTS CAUSING SERIOUS INJURY

We also were asked to review assaults on inmates and staff that occurred between January 1, 2018, and April 30, 2019, and resulted in serious bodily injury. For those incidents, we were asked to "provide an analysis of the department's actions in reviewing the circumstances of each incident and the actions taken to prevent them from occurring. This includes review of any criminal and investigative reviews, medical examiner reports, policies and video." In addition, we were asked to determine "whether the ineffectiveness of locks contributed to the conditions that resulted in the assault."

As a result of our review of ADC records, and with the help of ADC, we identified 17 assaults that fall within the "serious bodily injury" category during the relevant time period. All occurred in 2018. They include ten assaults on inmates by other inmates and seven assaults on corrections officers, some of which involved more than one officer and one of which involved a sergeant. We requested and reviewed all criminal and investigative reviews, medical examiner reports, and policies related to these matters. We requested and reviewed relevant video recordings related to those incidents for which video is available and which may have involved the ineffectiveness of locks.

A. Observations about the Conduct of Investigations

The investigations completed by ADC in each of these instances followed expected investigative practices. In each instance, the Office of the Inspector General of the Department of Corrections filed its report. The reports typically and appropriately include or refer to other investigations, including those completed by SSU. The investigations involve, and the reports reflect,

[26] These cases are filed by employee number.

interviews of the victim(s), suspect(s), and witness(es). The reports typically, although not each time, include a notation as to whether ADC referred the matter to the Maricopa County Attorney's Office for consideration for criminal prosecution. Not surprisingly, in most instances involving inmate on inmate violence, the victim inmate chose not to request prosecution. In short, nothing about the conduct of ADC investigations of incidents involving serious bodily injury appears unusual or inappropriate.

We also compared the assault reports with disciplinary actions. In most incidents involving injury to a staff officer, discipline was imposed.[27] We found no disciplinary files that imposed discipline for inmate on inmate violence. We assume this reflects the likelihood that inmates refused to testify or press charges, so determining the facts would be difficult.

Neither the investigative nor the disciplinary files include suggestions of actions that ADC can take to prevent future similar occurrences. We would expect such suggestions to be made in other reports, such as those from the warden, the chief of security, the NROD. We discuss the actions taken by ADC in 2018 and 2019 in Section V, above.

B. Ineffective Locks as a Contributing Factor

We were also asked to determine whether the ineffectiveness of locks at Lewis Prison contributed to the conditions that resulted in assaults causing serious bodily injury. We note initially that, in reviewing video evidence of the assaults when that evidence was available, we found most striking the casual attitude of the inmates who leave their cells, wander the unit, and enter other cells. The inmates evidence no concern that they are visible on video and they may be called to account for their actions. The presence of an officer does not seem to deter this behavior. The videos make very clear the accuracy of the comments we heard about inmate UAs being an accepted part of prison life at Lewis.

The incidents reviewed fall into one of three categories. In the first, effectiveness of the locks seems to have no relationship to the injury-causing event, often because the incident occurs when inmates are authorized to be out of their cells for meals or recreation or involves a situation with no indication that inmates are present without authorization.

[27] Inmates Trujillo and Valencia (9/29/18 assault of COII Peralta), Peters and Percy (10/5/18 assault of COII Ballentine); Mendoza (10/13/18 assault of COII Garcia); Garcia, Euceda, and Rodriguez (10/30/18 assault of COII Pasos); and Luna, Contreras and Zamora (11/22/18 assault of Sgt. Markowski and COII Cardoza) received discipline. Typically, discipline involved loss of all or some of the inmate's earned release credits, 30 days loss of privileges and visits, and 90 to 180 days in Probation Class III. We received no disciplinary files for the assaults on COIIs Garza and Avila (10/29/18) and COIIs Nash and Duran-Vargas on 12/30/18.

We include in this category Case 2018-10151, in which Inmate Lewis was stabbed as in ran from the dining hall; 2018-100252, in which Inmate Olvera was injured in an unwitnessed assault in the common area of House 2C/D; 2018-100275, in which three inmates assaulted Inmate Ellis between two housing areas; 2018-100431, in which an inmate assaulted COII Garcia while he was monitoring a metal detector as inmates passed through to lunch; and 2018-100499, in which Inmate Valdez was injured in Barchey Unit, which is an open yard. We also would include here 2018-100341, in which Inmate Mirza was beaten and kicked near a control room by two inmates. The investigative report does not indicate whether the inmates were outside their cells without authorization.

The second category covers those assaults for which we cannot tell whether inmate UAs contributed to the causes of the incidents, although a UA could have been a contributing factor. These incidents involve inmates who were assaulted or otherwise injured in a cell or other area not subject to video surveillance. Although video evidence for some of these incidents shows other inmates entering or leaving a cell, and one could surmise or guess that an assault occurred by inmates out of their cells without authorization, the evidence we saw does not allow us to conclude that the ineffectiveness of locks contributed to those injuries. We include in this category 2018-100251, in which Inmate McCormick sustained serious injuries that he attributed to a seizure and fall. Video evidence shows several inmates outside the cell who did not enter and others who entered but said they did so only after McCormick was injured; one inmate said he entered to help McCormick. We cannot determine whether any of the inmates visible on the video contributed to the assault or injury. The same concerns surround 2018-100123, in which Inmate Johnson was found unresponsive and in a puddle of blood in his cell. It is likely that the assault did involve inmates out of their cells without authorization, but we cannot reach a definitive conclusion based on the reports available. Similarly, in 2018-100010, Inmate Bologna's cellmate found him on the cell floor with serious multiple injuries to his facial area, after another inmate, Soriano, allegedly had told the cellmate he had a problem with Bologna. Video shows Soriano entering the cell, but nothing further can be seen. Finally, in 2018-100473, Inmate Bociung sustained injuries in an unwitnessed assault. The inmates who assaulted Bociung found him in a cell not his own, which suggests that he left his cell and accessed another without authorization. In addition, another inmate admitted that he went to give Bociung a "chin-check," but that it got out of hand. We think it likely that ineffective locks contributed to this injury, and video shows inmates entering the cell being visited by Bociung, but the fact that video does not show when and how the injury occurred results in our placing the incident in this category.

In a number of incidents involving assaults on officers, ineffective locks seem clearly related to the injury-causing incident. In case 2018-

100407, video shows that Officer Peralta was assaulted after responding to reports of multiple inmates out of their cells who were refusing to lock down. The assault in that case would not have occurred if the locks had worked effectively because multiple inmates would not have been in the pod. In 2018-100422, UAs also affected the situation that resulted in the assault on Officer Ballentine. That incident began when Officer Ballentine learned that two inmates had UA'd their cells and then attempted to move from one cell to another. Similarly, Officers Garza and Avila, in case 2018-100457, were injured when an inmate improperly out of his cell came to help two inmates who were reluctant to enter their cells. In case 2018-100460, Officer Pasos entered the area in which the assault was committed to lock down inmates who were out without authorization and who then pulled pins on several other cell doors. Sergeant Markowski, in case 2018-100484, encountered a situation in which at least six cell doors were open and at least eight inmates were out of their cells without authorization. Three of the inmates improperly roaming the common area assaulted Sgt. Markowski and Officer Contreras. A similar situation made possible the assault on Officers Nash and Duran-Vargas, who returned to an area after learning that inmates had UA'd their cells shortly after the officers had completed a security walk. See case 2018-100514. The video of that incident, which caused shock when it was broadcast, shows multiple inmates streaming out of their cells and assaulting the two officers. One of the assaults on an inmate also appears clearly related to UAs. In case 2018-100080, Inmate Mallory was assaulted in his cell. Unlike most such assaults, this assault begins with an inmate who is captured by video punching someone inside the cell, and later the fight spills into the area outside the cell, where it is clearly captured by video. At least four inmates are out of their cells and involved in the assault.

Video and written evidence document many more assaults related to ineffective locks but not resulting in serious injury. We find convincing evidence that the ineffective locks at Lewis Prison contributed to assaults on both staff and inmates.

VIII. MANAGEMENT OVERSIGHT AND ACCOUNTABILITY

We were asked to "review management decisions made by agency leadership [from January 2, 2018, through April 30, 2019] related to the management and leadership of Lewis prison, to include accountability for oversight of the safety and security related to the ineffectiveness of locks at Lewis prison and provide any recommendations for further action that may be warranted."

For most of the 16-month review period, Lewis Prison was under the immediate supervision of a management team headed by Warden Berry Larson. In December 2018, Director Ryan changed most members of that team by

reassigning two team members, including the Warden, and demoting other officers. Because the warden, deputy warden of operations, and all deputy wardens except one were replaced, there seems little value in reviewing the management decisions of this team. Director Ryan has already determined that it was not performing satisfactorily and has remedied that situation. The new leadership team headed by Warden Gerald Thompson has been in place only since approximately January 2019. Those we interviewed expressed the view that the new leadership team is strong and is working diligently to remedy the deficiencies in morale, training, cleanliness, discipline, and attention to detail that contributed to the problems at Lewis. There is guarded optimism that things are turning around at Lewis, although slowly, and so it seems premature to attempt to assess the success of a new prison administration based on just seven months' work, when it has been asked to clean up a situation that has been years in the making.

Director Ryan acted decisively and seemingly effectively to remedy perceived *leadership* deficiencies at Lewis that may have contributed to the inmate UA problem. We turn to whether it took ADC leadership too long to learn of the *lock* problems at Lewis or to recognize their seriousness and whether, once the scope and seriousness were known, leaders acted sufficiently quickly and decisively to remedy the problems.

According to statements from ADC, the top leadership team believed until fairly recently – and some, including the Director, still believe today – that the cell door locks at Lewis were not broken, but the inmates could jimmy their cell doors open if they capped the doors. In 2019, ADC issued this statement to media: "We firmly dispute the contention that doors do not lock at all. Officers assigned to work on the locks indoors report to us that the locks are functional. It's the inmate tampering that causes them to be able to open their doors."[28] Some senior leaders expressed that opinion during our interviews in June 2019.[29] In fact, it appears that by the end of 2017, there were many doors that could be capped and shaken open, some doors that could be shaken open whether capped or not, and a few doors that would "pop open" once pins were removed.

So when did Director Ryan learn that the doors, whether because they were capped or broken, sometimes failed to secure the inmates in their cells? In response to media questions, ADC released a statement saying that the

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[28] Quoted in D. Biscobing, *When did AZ DOC know of broken cell locks? 'Corrected timeline' released*, May 15, 2019 (KNXV ABC 15 News).

[29] SROD Tara Diaz, for example, in April 2019 sent around training materials that stated, in the "Cell Door Summary": "Inmates in the Morey, Buckley, and Rast Units [at Lewis Prison] have been able to tamper with their cell doors by inserting objects of various types in the doors to hinder the locking mechanisms for fully engaging and thereby securing the door. Locks on the doors function as designed when they are not tampered with. *The locks for the cell doors in these units are not broken[;] they are functional.*" (Emphasis added.)

director first learned about the scope of the problems at Lewis in May 2018. Given the Director's actions and statements to us, that date actually may be earlier than the date that he fully recognized the scope of the problem. In our first interview, the Director discussed the video that aired on Channel 15 in April 2019, which shows a December 30, 2018, assault on two correctional officers by several inmates who were able to get out of their cells seemingly at will. Ryan expressed surprise at the number of inmates out of their cells and the ease with which they got out. He said that although he received an email on December 30 about that incident, he got no written report advising that the event involved an assault on officers, and certainly nothing in it had alerted him to the extent of inmate UAs. He said that the Significant Incident Reports and the initial Incident Reports that he reviewed were very cursory and gave little hint of the seriousness of the incident. He therefore did not know, or if he knew intellectually he did not fully appreciate, the scope of inmates' ability to UA cells until he saw the video in April 2019.

During the same interview at which the December 30 video was discussed, Director Ryan played for us part of the video of the November 8, 2018, fire incident at Lewis's Rast unit that aired on channels 12 and 15. That video shows several fires being started by inmates in at least three locations in one pod at Lewis. It also exposes several inmates out of their cells and COs standing around, not doing much to put the fires out or secure the inmates. Ryan said the written reports of that incident were also cursory and unenlightening. He again became aware of the seriousness of the incident only when, at someone's suggestion, he watched the video. He appeared to have been shocked, when he first watched the video, to see that the event was quite serious and lasted approximately an hour and a half, and he was frustrated that leadership sat back and did not act affirmatively and decisively to resolve the incident.

ADC fairly quickly revised the timeline as to when Director Ryan knew of the inmate UA situation from late May 2018 to November 2017. Support for that date can be inferred because someone in leadership, presumably the Director, ordered the pinning of the doors of the cells at Lewis in November/December of 2017, a recognition that the locks alone were not holding. We asked for a copy of the directive ordering installation of the pins, but never saw one. Interviewees indicated that the impetus came from NROD Ernie Trujillo, as he had overseen ADC facilities at which pinning was used effectively. Discussions with Trujillo about pinning cell doors at Lewis seem to have begun in the summer of 2017. Nonetheless, the decision to pin by management indicates the understanding, by summer 2017, that the doors alone were not keeping the inmates in their cells.[30]

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[30] In our August 8, 2019, interview, the Director indicated that the decision to pin the Lewis doors may have come from NROD Ernie Trujillo and District Director Carson McWilliams, although he would have agreed.

From the statements and documents we reviewed and the interviews we conducted, we cannot tell when, precisely, the Director came to understand that some locks would not secure and to appreciate the seriousness of the problem at Lewis. Whether it was 2018, 2017, or even 2019 (when the Director expressed surprise at the extent of UAs shown in the videos), all dates seem late in the game. Overwhelming evidence shows that the inmates had been getting out of their cells for years. Inmates being able to get out of their cells without the permission or assistance of the correctional officers is a problem in the prison setting, a threat to the safety and security of other inmates and the officers.

Why did the Director of the Department not know earlier? It appears that he was misled into thinking the locks were fully functional and inmates UA'd only because the COs were not checking the frames and securing them.

Senior management should have clearly and fully advised the Director of the nature and extent of the problem and should have taken him to Lewis earlier so that he could assess the situation and view and randomly test the doors. A few interviewees indicated that when the leadership team visited Lewis, they were steered toward doors that had been capped, but otherwise worked.

This suggestion assumes, of course, that senior managers knew of the problems, as they should have known. If they did *not* know, fault lies with them for not knowing, but also with a leader who continued to rely on the perhaps not-well-informed senior managers. If senior management knew but failed to adequately inform the director, then some fault certainly lies with those senior managers. But managers usually do not rise to senior positions without knowledge of their jobs, a part of which is to accurately and adequately advise their superior so that he might make effective decisions on behalf of the agency. So if they did not fully report to the director, the question is why.

A few interviewees suggested that Director Ryan cultivates a culture in which employees fear to tell him negative information. While that seems contrary to a sign in his office soliciting information and input and emails we reviewed stating that he invites information and even complaints, we nonetheless heard from more than one interviewee that he surrounds himself with those who agree with him ("yes men" was the term used), and that some dare not disagree with him and slant reports to meet his expectations for fear of discipline or termination. Some anecdotes were shared to support these assertions. Most others, however, disputed these contentions and said that Director Ryan welcomes honesty and desires to be fully informed. The truth is difficult for us to assess from the outside and may, in fact, depend upon the employee's relationship with the Director. But regardless how it happened or whose fault it was, we conclude that the Director, for too long, remained surprisingly uninformed about the poor functioning of the locks and scope and

seriousness of the danger the inmate UA issue that resulted at Lewis posed to inmates and officers. That is not acceptable.

That belief that the locks were working does, however, explain the Department's multi-year failure to request funds to fix the doors at Lewis. The Director thought they were not broken, at least until late 2017 (to take the earliest stated date). It does not, however, explain why other decisive actions were not taken to ensure (a) that COs fully secured the doors, if that was believed to be the cause of the UAs, and issued disciplinary tickets for any inmates who got out of their cells, and (b) that mid-level supervisors were on the floor to actively mentor, assist, and supervise COs. If the failure to secure doors stemmed from lack of CO time (because of lack of staff), then the Department should have been aggressively requesting more money for staff and salaries and aggressively recruiting and training COs. In short, even if the Director was misled about the functioning of the locks, he bears the responsibility as the Director of the Department for not being fully informed. This is certainly so if he was underinformed because his staff feared to reveal to him the extent of problems. If the Director was adequately informed but disregarded the information, he bears responsibility for that as well.

We are confident that the Director accepts ultimate responsibility for the Department's functioning.

IX. OBSERVATIONS AND RECOMMENDATIONS

Although our primary responsibility in preparing this report was to impartially find and analyze the facts surrounding problems with doors and locks at the Lewis Prison, the Governor requested that we also provide recommendations for further action that may be warranted. We emphasize here, as we did when we accepted this assignment, that we do not possess particular expertise in prison management. We recognize that unique security considerations may affect the ability of ADC to implement changes that could be made without difficulty in other organizations. Nevertheless, our conversations with long-time employees of ADC and our review of the many materials provided us indicate that changes to ADC practices and procedures could help prevent the type of problems that we reviewed.

Locking System: Since the end of April 2019, the Arizona Department of Corrections has made a substantial effort to identify an alternative locking system that will provide safety for inmates and staff at Lewis Prison. We are confident those efforts will continue. Indeed, we learned at our August 8, 2019 interview with Director Ryan that a system and vendor have been selected. After ADC completes installation of a new system, procedures for assuring continued monitoring and maintenance must be developed.

Staffing: Continued attention to staffing the prison at an adequate level is essential. We regard it as significant that, for at least the last fifteen years, ADC has not been able to fill the number of CO positions authorized. The problem does not seem to be as much with attracting and training new applicants, but rather with retaining them once hired.

Increased salaries are one component of attracting and retaining staff. Several interviewees commented that staff had not had a pay raise for 13 years and, while the 10% pay raise recently authorized is nice, the increase is still low when apportioned over time. They also noted that signing bonuses, shift differential, and location pay have disappeared or diminished, reducing the amount that COs can make. Officers are not eligible for some of these supplements, even where they do still exist, creating the anomaly that a senior CO can make more than a junior officer. Several interviewees explained to us that pay in nearby jurisdictions may exceed ADC pay by nearly $10,000 per year, so once new COs obtain experience at ADC, they try to secure employment with Maricopa County or Pinal County.

Salaries are an important but not the only factor in attracting and retaining staff. A number of interviewees cited safety concerns and the lack of support from leadership, whether perceived or actual – that is, the feeling that supervisors and administration just don't have COs' backs. Corrections officers often mentioned the positive impact of supervisors appearing on the yard and taking time to train them. ADC should immediately develop programs that improve relationships between supervisors and officers. Until ADC institutes changes that allow the Department not only to hire but also to retain COs, reaching adequate staffing levels will be a recurring problem.

Budget: An effective budgeting process is essential to obtaining funds for adequate funding. We encourage ADC to continue to refine its process for developing a budget with priorities clearly defined.

Training: We understand that ADC has revamped the training program for corrections officers. Training for all levels of personnel should be ongoing. As is true for leaders of all large businesses, prison leaders must be trained in business processes, principles, and administration.

Security Checks: No matter what locking system is used, unauthorized access is likely to continue unless staff makes required security checks. Supervisory personnel must accept responsibility for assuring that required checks are timely and properly completed.

Revise the Reporting System: ADC's reporting system is complex and cumbersome. For instance, Post Orders require multiple reports for each incident that will or may lead to inmate discipline. As another example, ADC requires separate reports about security device deficiencies from staff, from

sergeants, from deputy wardens, from the warden, and from the Chief of Security. Often, the system does not make use of available technology. We recommend that the State consider whether and how to revamp and modernize the ADC reporting system in a way that eliminates redundancy and provides ready access and links to all documents relevant to a particular incident while also helping to ensure that the necessary information concerning an event is transmitted.

Communication: During our interviews, we learned that some COs had been instructed not to report security incidents or told that information should be filtered to make a supervisor or unit "look good." As a result, incomplete or misleading information occasionally reached upper administration. ADC has taken steps to emphasize the importance of communicating accurate information and should continue that emphasis. In addition, ADC should consider developing an electronic communication system that permits immediate contact when necessary.

Leadership: Both to increase employee morale and to stay current with problems developing within the prisons, top leadership should make frequent unannounced visits to the prisons. Moreover, ADC leaders must review and adopt modern prison administration techniques.

Funding: All of the mentioned "fixes" require additional financial resources. So while funding itself was not often mentioned, it is an integral part of fixing locks, increasing staffing, boosting staff pay, providing additional staff training, and procuring, installing, and training on a new electronic communications system.

X. CONCLUSION

Prisons play an important role in Arizona. Those who work there and those committed there by our justice system deserve a safe and secure environment. Lewis Prison has a problem with malfunctioning doors and doors inmates can manipulate to escape cells that are not otherwise secured by pins or padlocks. We attempted to isolate the causes of the problem so that they could be prevented or mitigated. We were not able to definitively document the scope of the problem, but evidence of it appears in videos showing inmates streaming from cells to attack correctional officers or other inmates and in the reports of malfunctioning security devices. This cannot be permitted in our prisons.

Recently secured funding recommendations to replace the door locking systems at Lewis Prison is a giant stride forward, and the Director expresses optimism that recently initiated programs at Lewis will assist in redressing many of the matters addressed in this report. We have made recommendations – and passed along recommendations from others – to attempt to further

remedy the causes of the problems that developed at Lewis. For the sake of our state, the inmates who are committed to our care, and the officers who serve in Lewis Prison, we must ensure that the Prison is secure.

We were greatly assisted in this project by the courteous and professional staff of the Department of Corrections. Without exception, each current employee responded promptly to all requests for interviews, documents, videos, and other assistance, tasks that took them away from their already-busy work schedules. We appreciate their cooperation and the opportunity to work on this project.

ATTACHMENT 1

Arizona Department of Corrections
ASPC-Lewis: COII Filled, Vacant, Total & Average Daily Inmate Population

Average Filled COII Positions (source: PIC files)

Unit	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
LEWIS BACHMAN SECURITY	HRIS data downloads (PIC files)			83.6	93.6	93.1	72.8	78.8	78.2	92.0	96.3	93.4	88.8	86.8	93.8
LEWIS BARCHEY SECURITY	were used for FY 2008 - FY			109.6	116.8	114.7	107.0	104.5	100.8	101.4	103.1	102.8	94.0	94.6	90.0
LEWIS BUCKLEY SECURITY	2019. The same source is not			132.2	132.5	133.4	127.3	131.7	127.0	123.5	128.3	128.3	121.6	117.5	102.5
LEWIS COMPLEX SECURITY	available for FY 2005 - FY 2008.			84.2	97.8	96.6	84.2	97.8	99.9	104.8	103.8	113.3	107.7	107.6	102.0
LEWIS MOREY SECURITY	The CO Hiring Report can			149.6	148.3	151.3	148.3	148.3	143.8	140.1	144.4	144.6	137.3	131.2	122.7
LEWIS RAST SECURITY	provide complex level data but			85.0	89.5	88.5	84.3	89.7	85.4	83.9	140.3	194.5	179.1	181.2	177.8
LEWIS STINER SECURITY	not unit level information.			138.4	135.5	136.5	131.7	136.3	131.4	129.8	133.0	134.0	122.4	119.3	122.2
OO-LEW-SUNRISE/EAGLE POINT UNITS				-	-	-	42.9	48.8	48.1	44.0	47.9	46.4	47.3	45.0	57.2
ASPC-LEWIS UNITS	803.0	699.0	744.0	782.6	814.1	814.1	798.4	835.8	814.6	819.5	896.9	957.3	898.1	883.1	868.1

Average Vacant COII Positions (source: PIC files)

Unit	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
LEWIS BACHMAN SECURITY	HRIS data downloads (PIC files)			9.0	6.6	5.3	8.8	4.1	10.3	13.0	8.8	11.6	17.2	18.3	10.3
LEWIS BARCHEY SECURITY	were used for FY 2008 - FY			14.4	5.2	8.7	9.5	6.0	9.2	8.7	7.9	8.2	17.0	16.4	21.0
LEWIS BUCKLEY SECURITY	2019. The same source is not			7.8	9.1	8.3	8.8	4.7	9.0	12.6	8.8	8.7	15.4	13.5	22.5
LEWIS COMPLEX SECURITY	available for FY 2005 - FY 2008.			14.0	8.2	5.8	12.1	10.8	19.1	21.8	18.3	16.8	25.3	21.9	24.0
LEWIS MOREY SECURITY	The CO Hiring Report can			8.8	10.7	5.3	6.3	5.8	8.3	12.0	8.6	8.4	15.8	14.8	16.3
LEWIS RAST SECURITY	provide complex level data but			7.8	3.3	3.0	5.0	3.2	7.6	9.2	60.3	13.5	22.9	19.8	18.2
LEWIS STINER SECURITY	not unit level information.			8.0	7.7	8.5	8.4	3.6	8.6	10.3	8.0	7.0	14.6	16.7	12.8
OO-LEW-SUNRISE/EAGLE POINT UNITS				-	-	-	4.2	3.8	4.9	9.0	5.1	6.6	13.8	16.0	3.8
ASPC-LEWIS UNITS	232.0	237.0	107.0	69.8	50.6	44.9	63.1	41.8	76.8	96.5	125.7	80.7	141.9	137.4	128.9

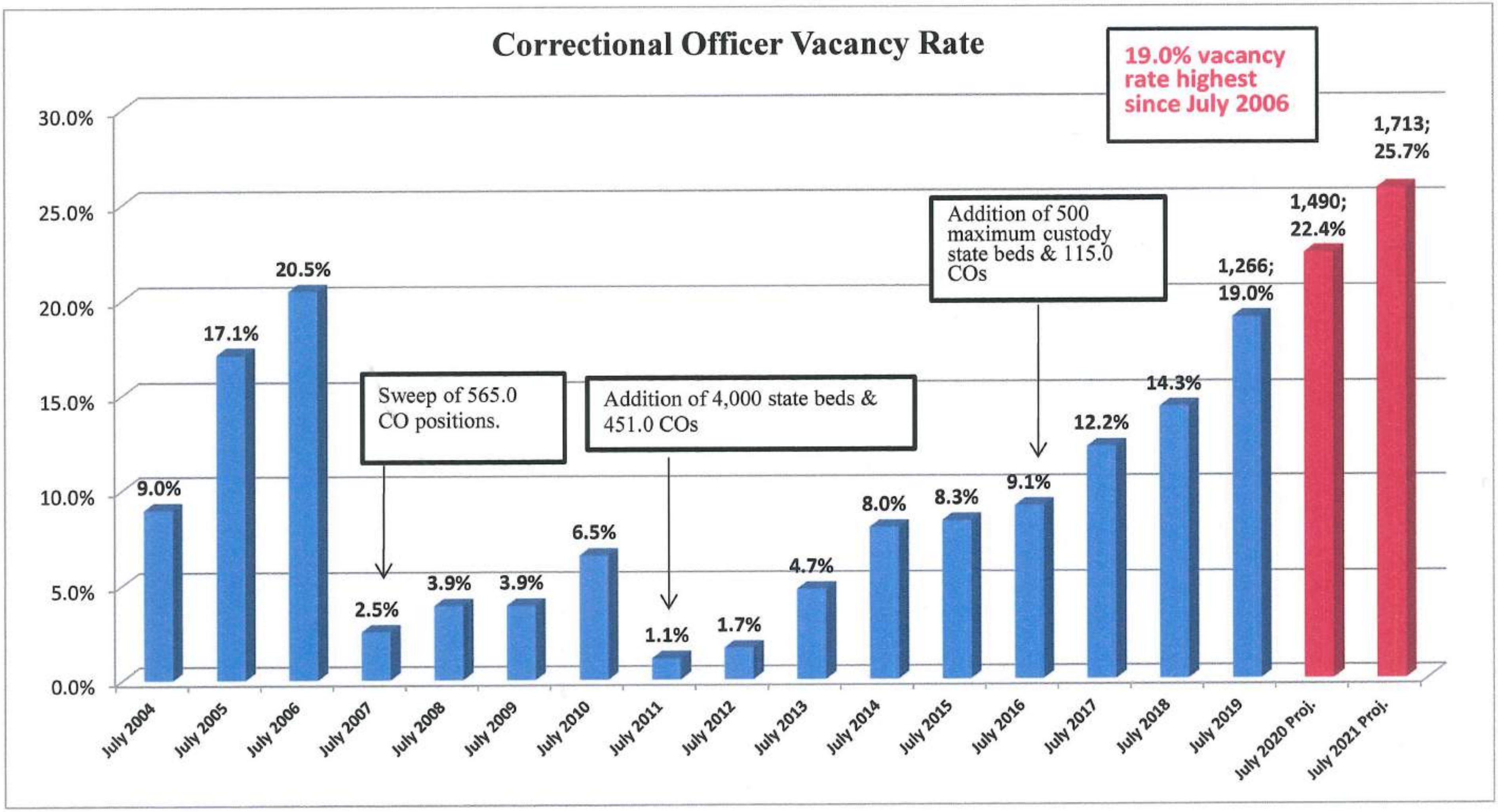
Total COII Positions (source: PIC files)

Unit	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
LEWIS BACHMAN SECURITY	HRIS data downloads (PIC files)			92.6	100.2	98.4	81.6	82.8	88.4	105.0	105.0	105.0	106.0	105.0	104.0
LEWIS BARCHEY SECURITY	were used for FY 2008 - FY			124.0	122.0	123.3	116.5	110.5	110.0	110.1	111.0	111.0	111.0	111.0	111.0
LEWIS BUCKLEY SECURITY	2019. The same source is not			140.0	141.6	141.8	136.2	136.3	136.0	136.1	137.0	137.0	137.0	131.0	125.0
LEWIS COMPLEX SECURITY	available for FY 2005 - FY 2008.			98.2	106.0	102.3	96.3	108.5	119.0	126.6	122.0	130.0	133.0	129.5	126.0
LEWIS MOREY SECURITY	The CO Hiring Report can			158.4	159.0	156.7	154.5	154.1	152.0	152.1	153.0	153.0	153.0	146.0	139.0
LEWIS RAST SECURITY	provide complex level data but			92.8	92.8	91.5	89.3	92.8	93.0	93.1	200.6	208.0	202.0	201.0	196.0
LEWIS STINER SECURITY	not unit level information.			146.4	143.2	145.0	140.1	139.9	140.0	140.1	141.0	141.0	137.0	136.0	135.0
OO-LEW-SUNRISE/EAGLE POINT UNITS				-	-	-	47.1	52.7	53.0	53.0	53.0	53.0	61.0	61.0	61.0
ASPC-LEWIS UNITS	1,035.0	936.0	851.0	852.4	864.7	859.0	861.5	877.7	891.4	916.0	1,022.6	1,038.0	1,040.0	1,020.5	997.0

Average Daily Inmate Population (source 2008 - Per Capita Report; FY 2009 - FY 2019 Count Sheet Database)

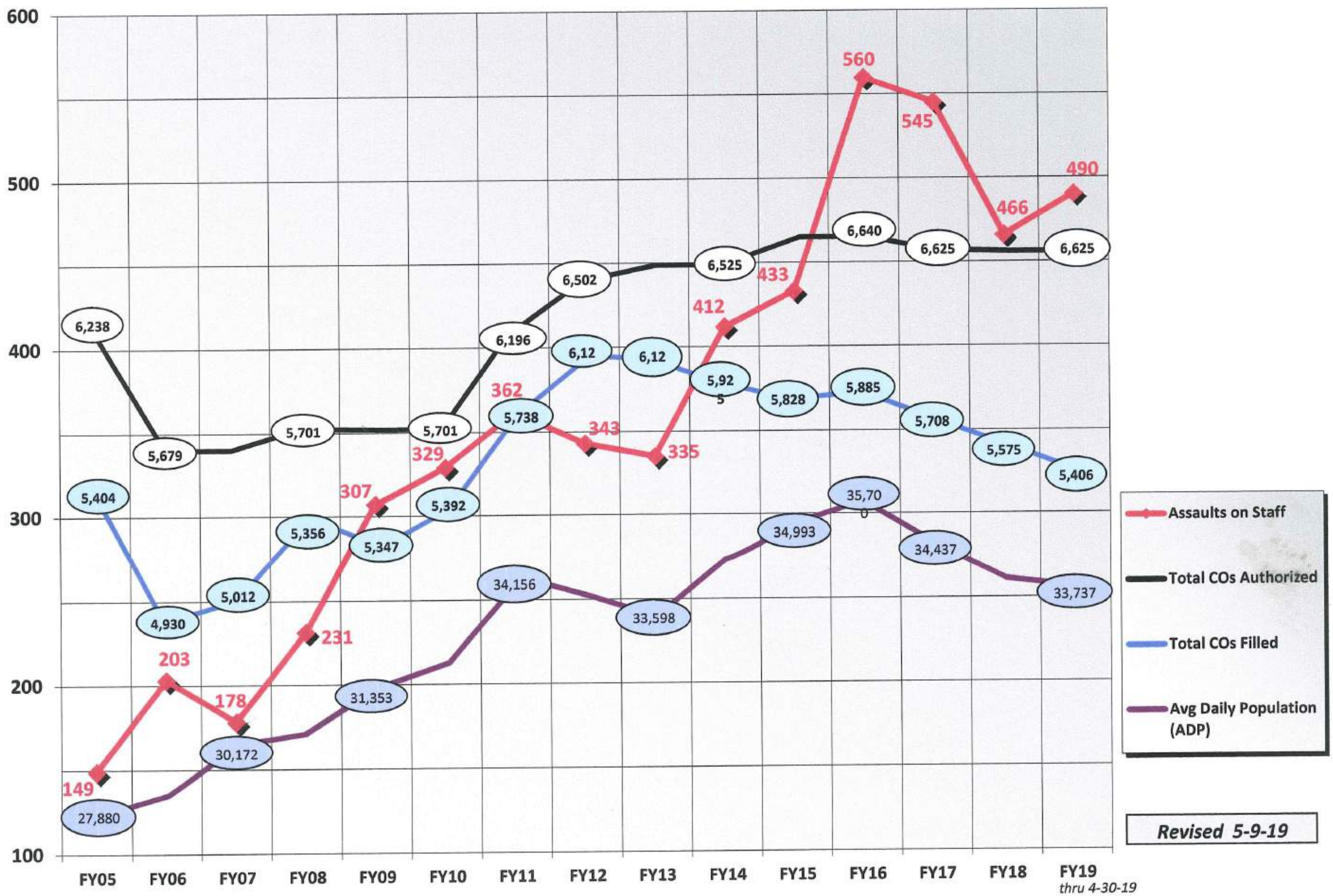
Unit	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
LEWIS BACHMAN SECURITY	703.4	700.8	735.3	733.0	809.9	841.8	829.9	799.8	776.1	792.6	775.0	767.6	727.4	690.1	770.1
LEWIS BARCHEY SECURITY	961.1	1,019.7	1,013.8	1,007.0	1,088.2	1,021.2	839.8	944.7	1,062.8	1,060.6	937.4	759.5	837.9	835.6	852.9
LEWIS BUCKLEY SECURITY	814.6	802.4	820.5	802.0	806.3	690.1	623.7	713.1	791.4	809.8	816.2	810.0	787.1	746.0	745.4
LEWIS COMPLEX SECURITY	-	-	-	-	12.6	11.9	12.4	12.2	12.2	11.3	12.3	11.5	11.0	11.5	11.7
LEWIS MOREY SECURITY	565.2	846.6	865.8	788.0	909.7	920.9	886.1	848.1	877.8	890.6	894.5	886.6	865.8	828.1	745.8
LEWIS RAST SECURITY	271.5	313.4	303.1	288.0	345.1	376.0	355.0	297.7	395.0	390.6	617.2	888.6	881.4	841.2	827.3
LEWIS STINER SECURITY	882.8	1,005.1	1,036.9	1,048.0	1,176.0	1,160.4	1,155.5	1,138.0	1,162.7	1,152.3	1,175.1	1,266.0	1,247.3	1,231.6	1,074.9
OO-LEW-SUNRISE/EAGLE POINT UNITS	-	-	-	-	92.1	150.6	304.5	367.0	394.5	391.4	385.1	379.0	367.2	343.1	378.9
ASPC-LEWIS UNITS	4,198.5	4,687.9	4,775.3	4,666.0	5,239.9	5,172.9	5,006.9	5,120.5	5,472.3	5,499.3	5,612.7	5,768.7	5,725.2	5,527.1	5,407.1

ATTACHMENT 2


Correctional Officer Vacancy Rate
19.0% vacancy rate highest since July 2006
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
9.0%
17.1%
20.5%
2.5%
3.9%
3.9%
6.5%
1.1%
1.7%
4.7%
8.0%
8.3%
9.1%
12.2%
14.3%
1,266; 19.0%
1,490; 22.4%
1,713; 25.7%
Sweep of 565.0 CO positions.
Addition of 4,000 state beds & 451.0 COs
Addition of 500 maximum custody state beds & 115.0 COs
July 2004
July 2005
July 2006
July 2007
July 2008
July 2009
July 2010
July 2011
July 2012
July 2013
July 2014
July 2015
July 2016
July 2017
July 2018
July 2019
July 2020 Proj.
July 2021 Proj.

ATTACHMENT 3

Incidents of Assaults on ADC Staff
FY05 - FY19



ATTACHMENT 4

Arizona Department of Corrections
Capital Improvement Plan
Prison Facility Locking Systems Requests

	FY 2011[1]	FY 2012	FY 2013[2]	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020[3]
ASPC-Douglas	$ 955,239	$ 1,018,598	$ 1,041,475	$ 1,093,548	$ 1,093,548	$ 489,868	$ 489,868	$ 489,868	$ 582,869	$ 578,022
ASPC-Eyman	2,879,922	3,201,645	2,859,448	1,823,950	2,323,950	1,823,950	1,823,950	1,823,950	5,546,176	5,777,485
ASPC-Florence	17,486,052	19,602,868	19,934,181	20,933,360	20,920,258	21,176,599	21,176,599	21,176,599	21,176,599	18,321,756
ASPC-Lewis	273,537	290,738	278,312	-	-	-	-	-	-	-
ASPC-Perryville	1,323,330	1,409,046	1,345,837	1,390,681	1,390,682	1,390,682	1,390,682	1,390,682	1,390,682	1,458,731
ASPC-Phoenix	609,525	660,417	1,028,720	1,034,880	1,034,880	-	-	-	-	-
ASPC-Safford	756,212	807,215	769,074	807,528	807,528	807,528	807,528	807,528	807,528	847,904
ASPC-Tucson	3,940,239	4,082,475	3,991,698	4,207,618	2,975,513	1,692,411	1,692,411	1,692,411	1,803,099	1,893,251
ASPC-Winslow	832,595	1,313,348	846,756	359,566	6,357	-	-	-	-	-
ASPC-Yuma	1,051,140	1,338,534	1,069,018	1,122,466	1,122,467	1,122,467	1,122,467	1,122,467	1,122,467	1,179,071
SUBTOTAL	$30,107,791	$ 33,724,884	$33,164,519	$32,773,597	$31,675,183	$28,503,505	$28,503,505	$28,503,505	$32,429,420	$30,056,220
P&O	3,571,100	3,771,667	3,964,804			included in subtotal			3,533,723	3,259,738
F&E Admin	-	-	350,000	350,000	305,000	305,000	305,000	305,000	300,000	300,000
TOTAL REQUEST	$33,678,891	$ 37,496,551	$37,479,323	$33,123,597	$31,980,183	$28,808,505	$28,808,505	$28,808,505	$36,263,143	$33,615,958

[1] FY 2011 Capital Improvement Plan (CIP) form 2 includes $2,032,109 not identified in the detail

[2] FY 2013 Capital Improvement Plan (CIP) form 2 does not include ASPC-Tucson, SACRC estimate of $15,557

[3] FY 2020 Building Renewal (BR) form 1 includes $2,647,184 not identified in the detail

ATTACHMENT 5

Arizona Department of Corrections
Capital Improvement Plan
Prison Facility Locking Systems Requests - Request vs. Appropriation

	ADC CIP Submission to ADOA	ADOA CIP REQUEST	AMOUNT APPROPRIATED ORIGINALLY	EXAPPROPRIATION	ADJUSTED APPROPRIATION	Project
FY 2005	$ 40,181,780	$ 7,900,000	$ -	$ -	$ -	
FY 2006	40,181,780	8,500,000	-	-	-	
FY 2007	47,253,773	8,500,000	5,200,000	-	5,200,000	ASPC-Tucson Rincon Unit
FY 2008	55,050,644	8,500,000	5,200,000	(5,200,000)	-	
FY 2009	65,210,205	3,500,000	-	-	-	
FY 2010	-	5,200,000	-	-	-	
FY 2011	35,711,000	7,000,000	-	-	-	
FY 2012	37,496,551	7,000,000	-	-	-	
FY 2013	37,479,323	7,000,000	-	-	-	
FY 2014	33,123,597	7,000,000	-	-	-	
FY 2015	31,980,183	7,000,000	-	-	-	
FY 2016	28,808,505	7,000,000	-	-	-	
FY 2017	28,808,505	7,000,000	-	-	-	
FY 2018	28,808,505	7,000,000	1,450,000	-	1,450,000	ASPC-Eyman SMU I (Phase 4 of 6)
FY 2019	36,263,143	7,000,000	-	-	-	
FY 2020	36,263,142	7,000,000	-	-	-	
SUBTOTAL	$ 582,620,636	$ 112,100,000	$ 11,850,000	$ (5,200,000)	$ 6,650,000	

Laws 2006, 2nd Regular Session, Chapter 345 (HB 2865), appropriated an initial $5.2M to ADOA for prison cell locks and cell door replacement.

- The initial appropriation was fully expended.

Laws 2007, 1st Regular Session, Chapter 257 (HB 2783), appropriated an additional $5.2M to ADOA for prison cell locks and cell door replacement.

- Laws 2008, 2nd Regular Session, Chapter 53 (HB 2620), reduced this appropriation by $2M.
- Laws 2009, 1st Special Session, Chapter 2 (SB 1002), reduced this appropriation by $3.2M.
- None of this appropriation was expended as Laws 2008 and Laws 2009 reduced this appropriation to zero.

Laws 2017, 1st Regular Session, Chapter 306 (SB 1523), appropriated $1.45M to the ADC Building Renewal Fund for prison cell locks replacement.

From FY 2012 - FY 2019 ADC has been appropriated between $4.6M and $8.5M annually for building renewal. The funding is not appropriated for specific projects. Before expending the funds ADC must have the proposed projects reviewed by JCCR. Since FY 2012 - FY 2019 ADC has allocated approximately 23% (or $12.5M) of these funds (includes the $1,450,000 appropriation for locks) toward locking and security systems over this timeframe.